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July 1961

Mental Hospitals

Hospital Journal
of the American Psychiatric Association

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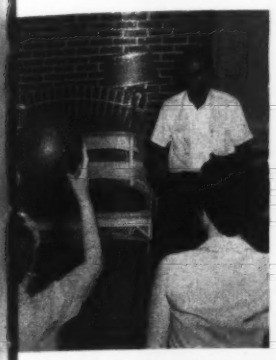

FINDING BURIED TREASURE IN THE HOSPITAL

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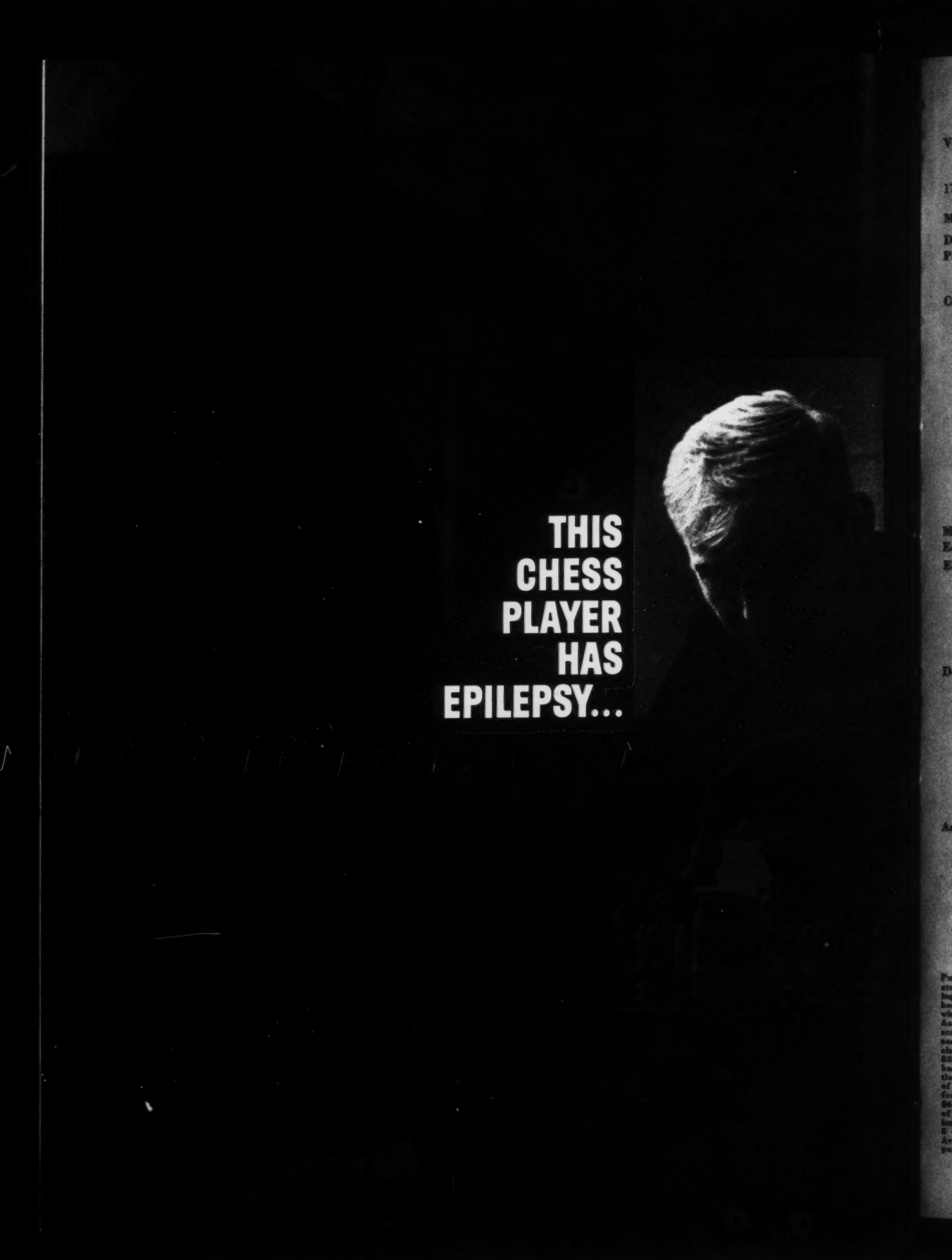
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Advertising
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Fred C. Michalove
(Eastern Representative)
44 N. Dean St., P.O. Box 533
Englewood, N.J. (LOwell 7-2120)
Gordon Marshall
(Western Representative)
30 W. Washington St., Chicago 2, Ill. (DEarborn 2-5148)

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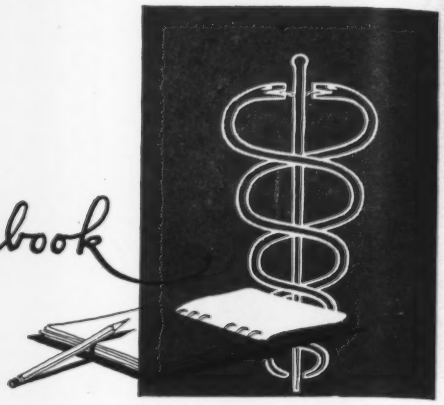
MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.

In place of his usual Notebook, the Editor describes some of the outstanding events which took place during the Third World Congress of Psychiatry, which was held June 4 through 10, 1961, in Montreal.

The Editor's Notebook



"AT A TIME WHEN THE WORLD needs to cooperate so much, and is often cooperating so little, there is special meaning to the Third World Congress of Psychiatry that opens its sessions in Montreal today," said an editorial in the *Montreal Gazette*. From June 4 through 10, 62 nations sent more than 3,000 delegates to this first western hemisphere meeting of the International Society, under the chairmanship of D. Ewen Cameron, M.D., a past-president of the American Psychiatric Association.

The purpose of the Congress was to discuss and evaluate the work in all areas of psychiatry from all parts of the world. Presentations ranged from talks by three Nobel prize winners to papers by young men early in their careers who may someday gain that coveted distinction. Countries whose programs in psychiatry and mental health are advanced and sophisticated shared their experiences with others whose concern with mental health and illness is emerging and developing.

There was, as the *Montreal Gazette* said, "an eagerness in cooperation, and freedom in the exchange of information and ideas that would solve many problems in other human spheres, if a similar spirit could only come into being." It is because this spirit was so exciting and stimulating that I am attempting to share with you some of my own response.

The three leading themes of the Congress were Phenomenology, presented by Dr. H. C. Rumke of Utrecht; Experimental Psychiatry, by Dr. Jules H. Masserman of Chicago; and Theory, by Dr. H. Ey of Paris. All seemed to agree upon the defects in current psychiatric practice and theory. In experimental psychiatry, said Dr. Masserman, there is need for clarification of our treatment methods and testing of their validity by means of objective and comprehensive studies. Dr. Rumke underscored the difficulties of maintaining so-called psychiatric objectivity, and was dissatisfied with our present phenomenological approach; this, he thinks, is incomplete, with too much emphasis on descriptive psychiatry. Dr. Ey stressed the same theme—lack of classification of phenomenologic description, and the need for nosological clarifications if we are to make genuine advances within sound frames of reference.

The three Nobel prize winners—Lord Adrian, Vice-Chancellor of Cambridge University; Dr. Linus Pauling at the California Institute of Technology; and Dr. Szent-Gyorgi, originally from Hungary and now at the Marine Biological Laboratory, Woods Hole, Mass.—discussed Scientific Creativity. Each presented his personal and individual ideas about the development and expression of creativity. Particularly interesting was Dr. Szent-Gyorgi's comment that a misunderstanding of democracy tends to stultify creativity.

"Nature is not democratic, and, as far as the intellect is concerned, does not make us all equal," he said. "Everything is being done to correct this undemocratic attitude of nature and make us all equals in the domain of the intellect as well, lifting up the retarded and knocking down the outstanding to the common level. If we spent half as much time and thought on the outstanding as we have on the retarded, leadership would not be such a scarce commodity."

Lord Adrian declared that the most potent factor in promoting new discoveries has been the introduction of a new technique or new piece of equipment; this type of technical progress will, he thinks, remain a major factor leading to new discoveries.

"However," he added, "every kind of science will stagnate without a new outlook from time to time. All I want to emphasize now is the importance of the tools we must use to look for new facts."

Dr. Pauling declared that thinking involves more than just solving problems. "In much of our thinking, we are groping to find out what needs to be done rather than how it needs to be done," he said. "Some of the most significant new ideas in science involve the recognition of new problems."

Dr. Pauling's comment seemed particularly appropriate to our own field. Each patient, each day's experience, each of our personal struggles should bring to each one of us a new insight—a new way of seeing and interpreting human experiences, leading perhaps to a totally new way of approaching one feature or another of mental illness.

University Convocations for the presentation of degrees tend to be colorful and exciting. The two in Montreal were no exception. At the University of Montreal, honorary doctorates of medical science were conferred upon three psychiatrists: Dr. Jean Delay of l' Académie Française, chief medical officer of the Centre Psychiatrique, Sainte Anne, Paris, and professor of the faculty

of medicine; Professor Daniel Lagache, philosopher and psychologist, professor of psychology and psychopathology at the Sorbonne, director of the Institut de Psychologie de Paris, and former president of the Société Française de psychanalyse. McGill University honored our own Dr. Clarence B. Farrar, editor-in-chief of the *American Journal of Psychiatry* with a degree of Honorary Doctor of Science; Dr. Henri Ey, secretary general of the International Organizing Committee for World Congresses of Psychiatry, and medical director of the Hospital Psychiatrique de Bonneval, Paris, was similarly honored, as was Dr. Walter S. Maclay, former senior medical commissioner of the British Board of Control, and principal medical officer in the British Ministry of Health. The degrees were presented by Dr. D. Ewen Cameron, professor of psychiatry at McGill.

Dr. Maclay, during his presentation on "Trends in the British Mental Health Service," made some fascinating predictions which have enormous significance to the development of psychiatric hospital systems in this country and in others in a comparable state of economic and psychiatric development. He stated that within 15 years the number of psychiatric beds required in Great Britain for each million population would be about 1,800; of these, 890 would be beds for long-term patients, 530 for medium-term (continued treatment), and 340 for short-term, acutely ill patients. "National, regional and single hospital figures all agree on the approximate number of beds," he said. "Despite minor variations in the figures, it would seem that 1.8 beds per thousand population will be required, as compared with the existing 3.4."

At the Third World Congress of Psychiatry, Montreal, organizers and hosts included (l to r) Dr. D. Ewen Cameron, Dr. Francis J. Braceland, Dr. Jean Saucier, Dr. Henri Ey, and Dr. John Dewan.

At the Third World Congress banquet, three psychiatrists were made honorary members of the Canadian Psychiatric Association. Dr. Jean Saucier, president of the C.P.A., presented the certificates of membership to Dr. J. J. Lopez-Ibor of Madrid, to Dr. William Sargant of London, and to the newest past-president of the American Psychiatric Association, Dr. R. H. Felix, Director, NIMH, Washington, D. C.

In keeping with the research orientation of the Congress was the surprise announcement of a $1,400,000 expansion of the psychiatric research and teaching facilities at McGill University. Funds came from provincial sources and from an anonymous donor. The new building, the construction of which will start in about six months, will be near the present research facilities of the Allan Memorial Institute of Psychiatry, the headquarters of the psychiatric treatment center of the Royal Victoria Hospital. It will not, however, replace existing facilities. To quote Dr. Cameron, professor of psychiatry at the University and director of the Institute: "We must maintain all present facilities at the Allan. Expansion in research is so rapid that we need all available space."

I was most excited to learn that, as a sort of postscript to the Congress, the original International Society for Holding World Congresses for Psychiatry has evolved into the first World Psychiatric Association. D. Ewen Cameron, M.D. of Montreal, was elected first president of this fledgling one-world psychiatric movement, and Francis J. Braceland, M.D. of Hartford, Conn., vice-president. Other officers include Dr. Henri Ey, Paris; Professor J. J. Lopez-Ibor, Madrid; Dr. William Sargant, London; and Dr. Paul Sivadon, Paris.

I cannot better conclude my brief and impressionistic account of this splendid experience than by quoting from Dr. Braceland's opening remarks to the delegates of the Third World Congress of Psychiatry:

"'There is now incontrovertible evidence that man-

Dr. Jean Saucier, President, Canadian Psychiatric Association (left) presented certificates of honorary membership to Dr. R. H. Felix, U.S.A., Dr. J. Lopez-Ibor, Spain, and Dr. William Sargant, England.

kind has just entered upon what is probably the greatest period of change that has ever been known. The ills from which we are suffering have their seat in the very foundations of terrestrial thought. Something is happening to the whole structure of human consciousness. A fresh kind of life is starting. In the face of such an upheaval and actually shaken by it, no one can remain indifferent.' (Teilhard de Chardin)

"It is certain that psychiatrists cannot remain indifferent, just as it is certain that wherever there is man, there will be emotions and wherever there are emotions, they will become disordered. It is our task to aid these individuals, whether they will be operating on earth or in space."

Matthew Ross, M.D.

'Thorazine'
Psychiatric Prescribing Information

ADULT INDICATIONS AND DOSAGE

Dosage should always be adjusted to the response of the individual and the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become excessively troublesome.

Mental and Emotional Disturbances of Everyday Practice—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals (increase should be more gradual in emaciated or senile patients) until achieving maximum clinical response. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but in some cases, such as discharged mental patients, daily dosages as high as 800 mg. may be necessary. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Hospitalized Psychiatric Patients—*Acutely agitated, manic, or disturbed patients: Starting intramuscular dose* is 25 mg. (1 cc.). If no marked hypotension occurs, an additional 25 mg. to 50 mg. injection may be given after one hour. Subsequent intramuscular dosages may be increased gradually over a period of several days—even up to 400 mg. q4-6h in exceptionally severe cases—until the patient is controlled. (In elderly or emaciated patients the dosage should be increased more slowly than in other patients.) Usually the patient becomes quiet and cooperative within 24 to 48 hours after the initial dose, at which time oral doses may gradually be substituted for intramuscular doses (mg. for mg. or higher). Even if control is not complete, oral doses may gradually replace intramuscular doses. During this period, oral dosage should be increased rapidly until the patient is calm. Usually an *oral dose* of 500 mg. a day is sufficient but, if necessary, the dosage may be gradually increased still further to 2,000 mg. a day or higher. *Less acutely agitated patients: Starting oral dose* is 25 mg. t.i.d. Subsequently, increase the amount gradually until an effective dosage is reached—usually 400 mg. daily is sufficient. *Duration of therapy:* It is important to determine the optimal dosage regimen and to continue treatment long enough for maximum clinical response. Maximum improvement is sometimes not apparent until after weeks or even months of therapy.

Alcoholism—*Starting intramuscular dose* for severely agitated patients is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. *Starting oral dose* for agitated but manageable patients is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

PEDIATRIC INDICATIONS AND DOSAGE

For behavior disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day. In children 5-12 years (or 50-100 lbs.)—not over 75 mg./day. In *severely disturbed cases*, 50-100 mg. daily has been used, and, in older children, 200 mg. or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery. Because contact dermatitis has been reported, avoid getting the solution on hands or clothing.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' may be unwanted in some patients. It is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects that have been reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

During 'Thorazine' therapy some patients have an increased appetite and gain weight. Usually these patients reach a plateau beyond which they do not gain further weight.

CAUTIONS

Jaundice: In the more than 14 million patients who have been treated with 'Thorazine' in the United States, the incidence of jaundice—regardless of indication, dosage, or mode of administration—has been low. Few cases have occurred in less than one week or after six weeks.

Jaundice due to 'Thorazine' is of the so-called "obstructive" type; is without parenchymal damage; and is usually promptly reversible upon the withdrawal of 'Thorazine'.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported in patients on 'Thorazine' therapy. Patients receiving 'Thorazine' should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted. Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells is sometimes observed in patients on 'Thorazine' therapy. If not accompanied by other symptoms, it is not an indication for discontinuing 'Thorazine'.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants, such as barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If it is desirable to administer a vasoconstrictor, 'Levophed' and 'Neo-Synephrine'* are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Causes of Vomiting: The physician should always bear in mind that the antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some of them appear to be due to photosensitivity, and it is advisable that patients on 'Thorazine' avoid undue exposure to the summer sun.

Extrapyramidal Symptoms: With very large doses of 'Thorazine', as frequently used in psychiatric cases over long periods, there have been a few patients who have exhibited extrapyramidal symptoms which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug withdrawn. These symptoms can also be controlled by the concomitant administration of standard anti-parkinsonism agents.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This, however, is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

In comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.), and also in patients under the influence of large amounts of barbiturates or narcotics.

AVAILABLE

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50, 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains chlorpromazine hydrochloride, 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, chlorpromazine hydrochloride, 25 mg.; ascorbic acid, 2 mg.; sodium bisulfite, 1 mg.; sodium sulfite, 1 mg.; sodium chloride, 6 mg.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, chlorpromazine hydrochloride, 25 mg.; ascorbic acid, 2 mg.; sodium bisulfite, 1 mg.; sodium sulfite, 1 mg.; sodium chloride, 1 mg. Contains benzyl alcohol, 2%, as preservative.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains chlorpromazine hydrochloride, 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains chlorpromazine hydrochloride, 10 mg.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains chlorpromazine, 25 mg. or 100 mg.; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles. (Each cc. contains chlorpromazine hydrochloride, 30 mg.)

Before prescribing 'Thorazine' in any indication other than those given here, the physician should be familiar with dosage, side effects, cautions and contraindications for such indications. This information is available in: *Thorazine® Reference Manual* and *Physicians' Desk Reference.*

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*'Levophed' and 'Neo-Synephrine' are the trademarks (Reg. U.S. Pat. Off.) of Winthrop Laboratories for its brands of levarterenol and phenylephrine respectively.

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that Thorazine® has in
its seven years of clinical use–

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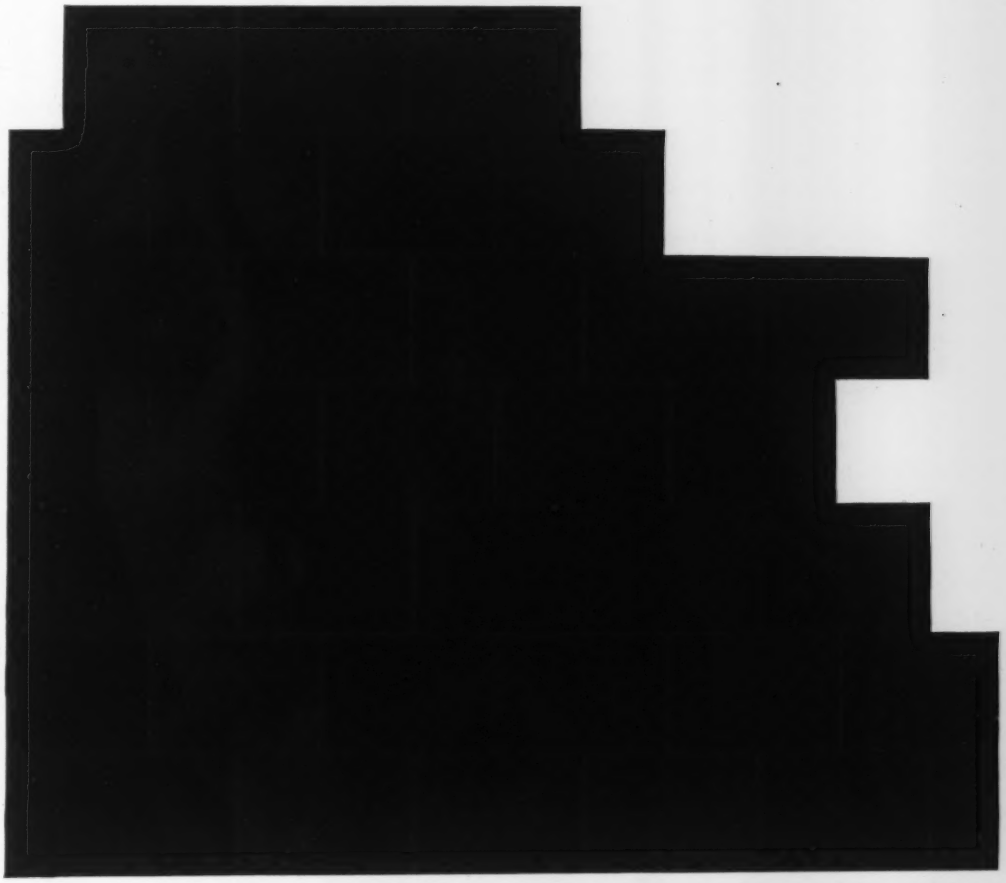
A fundamental drug in psychiatry.



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PREADMISSION VISITS

Encourage Positive Attitudes

By PHYLLIS POLAND
Casework Supervisor, Social Service Department
Allan Memorial Institute of Psychiatry
Royal Victoria Hospital, Montreal, Canada

WHEN A PERSON becomes mentally ill, his family is in a state of crisis[1] and, temporarily, forms a unit of ill health. Psychiatrists, recognizing this, increasingly stress consideration of the whole family during treatment, and not just the patient alone. This trend calls for improved communication between the family and the hospital. To facilitate such communication, the social service department at the Allan Memorial Institute of Psychiatry has established a new service of preadmission visits made by staff workers to the homes of patients and their families.

The amount of time which elapses between the onset of illness and the beginning of treatment is very important. Home visits are an attempt to put into practice the concept that treatment and rehabilitation should begin as soon as the diagnosis is made. Combining this theory with one of the major aims of the Institute—to return the patient to his social milieu as soon as possible—the visiting social workers try to mobilize early family cooperation in treatment and in planning for social rehabilitation.

Orientation is One Purpose—

The visit is also intended to prepare the patient for treatment and to lessen his anxiety and that of his family. Studies concerning enforced, emergency separation due to civil disaster, migration, or illness leave no doubt about the detrimental effects of such separation. The World Health Organization recognized this when it recommended that in civil disaster all members of a family should be evacuated together and that specific resources should be made available so that people can get and give information in order to reorient themselves. During the preadmission visit, the social worker helps to reorient the patient by preparing him for unfamiliar hospital routines and informing him to some extent about what his therapist and others on the team will do for him.

From the relatives' point of view, the preadmission home visit by a member of the staff is evidence of the hospital's interest in the family as a whole. The social worker, by discussing their immediate social problems and helping them to plan solutions, helps to set the stage for future cooperation. At the same time, she emphasizes the hospital's desire and need for family help and discusses specific things relatives will be asked to do during the patient's treatment. She tells them how to keep in touch with the doctor and the hospital, and invites them to attend relatives' group meetings and to participate with the patient in the evening recreational program. In this way she accomplishes the dual purpose of involving the family and reassuring the patient that he will not be isolated from them.

—Therapeutic Support Another

The concept of crisis is also involved in the establishment of this service. Caplan and his associates[2] define a crisis as a period of acute disequilibrium, during which the person is faced by a problem of basic importance, which cannot be solved quickly by his normal range of problem-solving mechanisms. Whether the outcome of the crisis posed by an acute mental illness is in the direction of greater mental health and maturity, or towards further mental deterioration, depends in a significant degree upon the help or hindrance, during the period of crisis, of the key figures in the patient's emotional milieu. These include his family and those professionals

[1] *Ackerman, Nathan W.: The Psychodynamics of Family Life, Basic Books, Inc., New York, 1958.*

[2] *Caplan, Gerald: Comprehensive Community Psychiatry, a lecture delivered at the Institute on Community Mental Health, Honolulu, October 1960.*

Parad, Howard J., and Gerald Caplan: A Framework for Studying Families in Crisis, Social Work, *5:3:3-15, July 1960.*

who are designated to help him. Caplan states that during the period of crisis, minimum therapeutic intervention may tip the emotional balance towards mental health. It is obvious that this is also the best time for a professional attempt to swing the balance of the whole family unit toward health.

On a practical level, we have learned that after admission it takes considerable time to enlist the family's help, if indeed it can be secured at all. At first they tend to deny that mental illness exists. Next they try to separate themselves first from the patient, and then from those who look after him. These attitudes arise from the false expectations most people have about psychiatric treatment; these expectations seldom include their own participation in the treatment of a sick relative. On the contrary, the only solution which occurs to them is to unload the sick person on the hospital, and then wait for him to be cured and returned home. The family's decision to "hand over the patient" and withdraw, at least temporarily, is often based on a lack of knowledge about what relatives can do personally and what the hospital will "allow" them to do. These passive attitudes and false expectations are reinforced if the family is not seen until after the patient has been admitted. The social worker's task of changing these attitudes will be easier before the patient has been hospitalized.

Family Resistances Reduced—

Our day-to-day experience of working with families only after the patient has been admitted confirms the value of preadmission visits. If no contact has been made prior to admission, families offer considerable resistance, both open and hidden, to our requests for them to visit the hospital. When they do come, they show much anxiety which must be dealt with before they can enter into a positive working relationship.

On the other hand, families welcome the suggestion of a preadmission visit with eagerness and relief. When we request that as many family members be present as possible, the immediate relatives sometimes arrange to leave work early and often gather together other relatives and even close friends. After the visit, they spontaneously call the worker for further discussion of ideas or problems and to ask additional questions. It is significant that, although they may phone frequently, they seldom apologize for "bothering" the worker, which gives us the impression that because of the preadmission visit, they consider it their duty and their right to communicate freely with the hospital.

Workers on preadmission visits find that the families' anxiety often is so acute that they are paralyzed by it and unable to recognize immediate problems, let alone do anything about them. One wife, for instance, had reported to her husband's office that he could not come to work because he had "flu." They thought that his job might be endangered if it was known that he was mentally ill. They had "forgotten" that the company would require a medical certificate to make arrangements about salary and hospital insurance, although they had been through the same process two years earlier when the patient had had an operation. They were greatly relieved when the worker reminded them that arrangements could be made confidentially through the company's medical department and that a decision about what to tell the husband's fellow employees could be deferred until later.

A common problem, when mental illness affects a mother, is the care of the children during her hospitalization. The worker making a preadmission visit can prevent a difficult situation by helping the family to plan ahead—perhaps to get a relative or friend to supervise the household or the children, or to engage a homemaker. If arrangements are not made until after admission, the father may endanger his job by staying home to care for the children, or the mother will want to leave the hospital to look after them because she knows they are upset. A hasty solution under such pressure may be detrimental to the future emotional health of the entire family, particularly if it involves placing the children in unfamiliar surroundings to be cared for by strangers.

The preadmission home visit provides an excellent opportunity for the social worker to observe areas of mental health as well as ill health in the family milieu. These will be apparent in the way in which the family copes or does not cope with problems arising out of the crisis and how they mobilize themselves to solve difficulties. The worker can help them to rediscover ways in which they worked out similar problems in the past and how these could be applied to the present situation. For instance, when the mother went to the hospital for the birth of her last child, who cared for the other children? This reminder to the relatives that they are capable of solving problems themselves does much to increase their self-confidence and encourages them to find solutions for their current problems.

—Doctor and Nurse Informed

Seeing the family at home before the patient has been admitted enables the social worker to obtain dynamic information about family values and interpersonal relationships. Once the patient is in hospital, the family is divided into two parts—the patient and his relatives—and the nature of the communication between them is altered. Social workers frequently observed this changed relationship in the relatives' group meetings where the two questions asked most frequently were: "What shall I talk about when I come to see him?" and "How shall I treat him when he comes home for a visit?" It was as if the family members were talking about a stranger.

Needless to say, information gathered during the preadmission visit is useful to the therapist and to members of the treatment team who work under his supervision. It helps the doctor and nurse to be better prepared to receive their new patient. It gives the social worker herself a broad picture of the problems to be solved before the patient returns to his community, of the strengths within the family which can be utilized, and of the areas needing further exploration and clarification.

Modern treatment involves the harmonious work of a complex team of professional people from a number of different disciplines. If all members of the team are informed as early as possible about the patient's family situation, they can treat his illness more effectively.

Developing A Social Service Department

By EDWARD L. DAVIS, M.S.
Psychiatric Social Work Consultant
Division of Mental Diseases, Mental Health Commission
Jefferson City, Missouri

A STATE MENTAL HOSPITAL offers the professional social worker an opportunity to meet a real test of his professional competence. This kind of hospital often is plagued by a staff shortage, low salaries necessitated by budget limitations, and excessive case loads. However, these deficiencies make the satisfaction of establishing a needed service all the more rewarding. This paper will describe the development of a social service department in a state mental hospital. The author hopes that his presentation of the department's policy development and administrative process will assist others who are facing a similar challenge and responsibility.

The Setting

State Hospital X (as it will be referred to in this paper) occupies a number of buildings on 1,060 acres in a small, conservative, midwestern town. It has 2,300 mentally ill patients and 980 employees who are affected by all of the limitations and problems often encountered in such institutions. These were meaningful facts to those who organized the hospital's social service department, but it was even more important for the social workers to be thoroughly familiar with the hospital and its administrative staff.

In April 1955—the beginning of the period covered by this report—an acting superintendent, serving in a caretaking capacity, refused to hire professional staff for the hospital unless he had the division director's approval. This was an awkward arrangement. The hospital staff was too limited in number and capacity to carry out its basic function of treating and returning patients to the community (a condition which improved later under the leadership of a new superintendent). Eventually, the division director employed a chief social worker and two psychiatric social workers. As a result of this unfamiliar hiring procedure, some of the hospital personnel regarded the new workers with suspicion.

In this situation, the social service staff could not move too rapidly for fear of further alienating the personnel. Their problems were all the more difficult because the hospital, which had opened in 1851, had never employed a social worker until 90 years later in 1941. Even then, there never were more than two workers in the department and their duties were limited to routine history taking, shopping for patients, planning parties, and some occasional patient-centered work. The hospital staff had included a fully trained psychiatric social worker only once—for approximately three months.

The new chief social worker had to develop and improve departmental policies, outline functions, and inform other hospital staff members of his actions. He knew that his position demanded that he make many decisions. One of the first was: Right or wrong, a decision must be made.

The Principles

The social service program should not usurp the functions of other departments, but should complement them. The new staff developed the department's functions, placing special stress on obtaining adequate social histories through interviews with relatives, setting up a discharge and aftercare program, and participating in casework treatment of patients. They communicated these ideas to the hospital staff by means of individual conversations; participation in staff meetings; and written statements, distributed to the staff and placed in the hospital newspaper. They made a special effort to work in a collaborative manner with other department heads and their staffs.

A social service department can function adequate-

ly on[e] when its director and staff firmly believe that its prog[ram] can improve and that it has a potential for grow[th]. Members of the hospital staff expressed varied reacti[ons] to the social workers' activities. Some accepted them, others maintained a reserve that bordered on suspicion. During this period the social workers acquired feelings of frustration and fear of failure. But they continued on, impelled by the tremendous amount of work to be done—social histories to be taken, patients in the acute and intensive treatment area needing service, and hundreds of patients in the hospital ready to go home if they could be identified. While meeting these needs, the department adopted the unofficial motto, "It can't get worse—the only direction to go is forward."

To achieve departmental growth and be accepted as professional members of the hospital staff, the social workers had to demonstrate the importance of their functions and become valuable to patients and other personnel. The workers followed the principle of breadth rather than depth of function. They centered their initial efforts in the acute intensive treatment building; two of them shared the intake social history responsibility, service to patients on the ward, and aftercare treatment. Another worker was responsible for the discharge and aftercare program for the rest of the hospital. When the hospital eventually employed another worker, he was assigned to an area which had not been covered previously.

The Scope

Some people, with justification, might question this "breadth" procedure, but it does have definite advantages. In broadening their sphere, social workers dealt with patients who had never experienced such contact before. As trust grew, patients approached the social workers to seek assistance in contacting families and relatives, ask for help with release planning, and discuss problems they were having with the hospital or their families. Mrs. K., a rather regressed, hostile patient, asked the social worker in her area to contact her family and help to restore the break that had occurred between them many years before. Eventually, patients were referring social workers to other patients!

The social workers also helped to bring about the development of small psychiatric teams in the hospital. Physicians who had stated that they did not like social workers—usually referring to them as a group of "do-gooders"—began to relate quite well to the individual social worker assisting them in a specific area.

The collective power of the medical staff is an important factor in a hospital, and each department must act to gain the support of this group. Although individual and group discussions are helpful, the most positive results occur when the physician and social worker become vital members of a team.

The development of psychiatric teams is essential to the establishment of a social service program and offers two advantages to the department director: (1) he can formulate policies at the department level but implement them at the team level, (2) it is unlikely that he will be accused of "empire building" when requests for additional social workers come from physicians who need the workers' assistance to expand their services. For instance, one psychiatric social worker was assigned to assist the doctor in charge of the so-called criminal section. The doctor's complete satisfaction with the social worker prompted him to request the services of three additional workers.

A social service staff must be adequate in number to carry out its program. But how can this be achieved? State Hospital X's new superintendent wanted professional social workers on his staff, and, fortunately, the hospital was located only 28 miles away from a school of social work. In the fall of 1955, a training consultant from the National Institute of Mental Health visited the hospital and the school to determine whether or not a training program for psychiatric social workers was feasible. The consultant helped in making arrangements with the school to establish a teaching grant and training grants for students utilizing NIMH funds and to coordinate with a work-study program financially supported by the hospital.

Training is an essential function of a hospital, and a training program is one way to develop a professional social work staff. The superintendent encouraged, approved, and supported the program. He was willing to use hospital funds to help pay the supervisor and to establish work-study payments for students interested in psychiatric social work. In September 1956, the training supervisor received a joint appointment as training consultant and student supervisor at the hospital and a faculty appointment as an assistant professor in the school of social work.

The Procedures

The supervisor established a definite procedure for work-study trainees. Students who have been accepted for graduate training in the school are eligible for the hospital's work-study program. Each June, any student who has received his bachelor's degree and is interested in the program may be employed as a case-aide in the hospital for three months—a period of mutual evaluation. At the end of this time the work-study agreement may be terminated by either the student or the hospital.

If the student continues in the program, he spends his first year in the regular generic course prescribed by the school and does his field work concurrently in the specified hospital. (The program has been expanded in order to train workers for other mental hospitals in the state.) The student spends his second year in the hospital full-time from June through January. As a work-study employee, his official block placement extends from August through January; he commits himself to work one year for each year of schooling he received in social work. Three students were accepted as trainees at the beginning of the work-study program which is now an integral part of the over-all hospital program.

The social service program must be related to the total hospital program and to the community in terms of serving people. A hospital needs the community's resources of welfare, vocational rehabilitation, public health, schools of social work, and other groups; there-

fore, its social service department should take the initiative in developing a relationship with these valuable allies by means of:

1) Personal contact made by the social service director (or his staff) with each agency.
2) Delineation of areas of mutual concern.
3) Joint problem-solving discussions centered on areas of concern.
4) Written agreements which clearly outline functions of the various agencies in relation to the social workers.
5) Clear lines of communication established between the agency and social service staff to expedite problem solving and necessary changes in procedure.
6) Cooperative attitudes encouraged among the members of both agency and social work staffs by the directors of each.

For instance, a release program for patients is arranged with licensed nursing homes. Institutional advisory nurses from the State Division of Health give nursing supervision to all patients placed in the homes and, thus, supplement the supervision of the hospital's professional social worker. This is extremely important in cases where the patient is receiving insulin or other special medication.

The Problems

This cooperative approach also must be applied within the hospital. A state psychiatric hospital is a composite of many disciplines joined together by mutual concern for the patient. The hospital superintendent must exercise great skill in welding these units together so that they will function properly.

The social service department must commit itself to a policy of aggressive action toward its own successful operation, but be willing to compromise or change for the total success of the hospital program. There are no definite rules about when or when not to compromise; such action must be based on judgment and experience. Desirable compromise occurs when there is a proper understanding between the superintendent, the social service department, and the hospital personnel as a whole. The social service department, through its director and staff, must have a good working relationship with other departments. A degree of rivalry often exists between departments, and social workers should do their best to keep it to a minimum. A statement made by the coordinator of adjunctive therapy illustrates this rivalry: "Psychologists get all the pay, social workers get all the credit, and we get all the work." But interdepartmental understanding is easily achieved when social workers are courteous and show a genuine interest in the activities and problems of others. It is helpful for the social service staff to participate in the training and orientation sessions held by other departments.

A crisis can be utilized to develop programs, and is the truest test of interdepartmental cooperation in a hospital. In February 1956, Hospital X had a severe fire which destroyed the administration building and several ward areas. No lives were lost, but the destruction of facilities reduced the hospital's intake work and caused greater emphasis to be placed on discharge functions. One of the social workers was transferred to a neglected treatment area of the hospital which houses the so-called criminally insane male patients. Since the social worker was female, her assignment to an area of "potential danger" was criticized. However, she had received the assignment because she was available, had considerable ability, and performed well in difficult situations. Her performance in this case proved her value.

Leadership is essential in program development. In the social service department, leadership is shared by the entire staff. They discuss their problems, policies, and functions and reach mutual agreement about a course of action. Sometimes, in an effort to contribute to over-all hospital policies, they present their ideas and suggestions to the superintendent.

While the department director's policies and programs often reflect the thinking of his staff, he frequently must stand alone in making a decision. The permissiveness of some casework situations does not always apply to an administrative problem, and his decisions may be questioned within his own professional family. However, if the director is fair, listens to his staff members, encourages their efforts toward independent thinking, and supports their own decisions whenever he can, they will represent a solid unit to the rest of the hospital. This unity is enhanced by the fact that the director, supervisors, and workers carry the responsibility for direct service to patients and their families.

The Potential

A social service department has greater potential for positive growth and development when it has the full support of the superintendent and the hospital staff. The department must share credit for successful decisions with the hospital. For example, from July 1958 to June 1959, 478 patients were released through the efforts of the social service discharge program. Only 13 per cent of these returned from leave, but the total rate of returnees from the hospital's other discharge programs was 35 per cent. When the director reported this fact at a medical staff meeting, he was careful to give credit to all who deserved it. Thus, the success became a source of pride for the entire hospital and not just a departmental statistic.

Many social service departments in state hospitals are small, but this in itself can facilitate personalized relationships between the staff, supervisors, and director. The director, in delegating authority and functions to the supervisors and workers, should be constantly aware of their individual capacities and effectiveness. He should not isolate himself from the staff, but should maintain positive interpersonal relationships. One of the real stimulations of social service, in addition to working with clients and patients, is the interchange one has with creative, articulate people. This interchange should be encouraged through staff meetings and individual discussions.

The social service department at Hospital X grew out of a challenge—a challenge that brought forth better service for patients and their families, improved condi-

tions within the hospital, and helped to unify the community and the hospital. In June 1955, there were only four full-time social workers on the staff and no students in training; but by June 1961, the staff included 12 workers and there were 11 students. Credit for these achievements belongs to many individuals and groups. In particular, the author would like to acknowledge the assistance of Alvin C. McDaniel, M. S., Senior Psychiatric Social Worker, Farmington State Hospital, Farmington, Mo.; Barbara Wickell, M.S., Psychiatric Social Worker III, Illinois State Psychiatric Institute, Chicago, Ill.; and D. R. Whitesell, M.S.W., Assistant Professor of Social Work, School of Social Work, University of Missouri, Columbia, Mo., in preparing this paper.

Can We Be Psychotherapists?

By DR. WHATSISNAME

With 200—or is it 300—patients per doctor, who can do psychotherapy? The answer is: You can, doctor, you can. You will throw up your hands and say that there is no use trying psychotherapy in any form. To say that is to confess defeat and to justify losing touch with your patients. If you will but aim at psychotherapy, you will compel yourself to think a little about what the patient is trying to say through his psychosis. You will wonder about the meaning of the apparently meaningless ideas or words. If the tempo of work permits, you can do this with each admission. Even in a ward for the chronic, there is a point of entry, a time when the patient is a "new" one for that ward. Here is the time to seek the rapport—to make the point of entry a port of entry. And there are those hundred-and-one occasions when something happens to justify a progress note—a cut finger, filling out a legal document, an attempted elopement, or a fall on the bathroom floor. Whatever brings the patient face-to-face with the doctor brings the opportunity for a figurative clasp of hands.

Psychotherapy? No, not if psychotherapy means a couch or a king-sized fountain pen. Not if you are obsessed with the 50-minute hour. Not if you seek to unwind the long, long trail from the symptom to the trauma, from the trauma to the womb. Not if you try to reconstruct the ego from the fragments of the id. But suppose you stretch that wonderfully elastic word to cover any meaningful human contact that makes a person feel better, feel wanted, feel understood. If you will buy psychotherapy at that modest price, then the hospital ward does offer some opportunity. Perhaps even so light a touch, so thin a caress may (as it was written in 1605) "cleanse the stuffed bosom of that perilous stuff which weighs upon the heart."

On surveying the abilities and preferences of elderly male patients, ward personnel and activity therapists discovered that the likes and dislikes of elderly men are not necessarily the same as their own.

Finding BURIED TREASURE in the Hospital

By ROBERT SOMMER, Ph.D.*
Research Psychologist
and IRENE WATSON, R.P.N.
Director of Ward Activities
The Saskatchewan Hospital
Weyburn, Saskatchewan, Canada

OUR WARDS were filled with hidden treasures, but until recently the annual hospital inventory proceeded too conventionally to uncover them. We knew precisely the number and nature of our physical plant's facilities and equipment. However, we had never inventoried the most precious of all our resources—the talents and skills of our patients.

One day, our music therapist mentioned that, on continued treatment wards, she frequently "discovered" patients who played musical instruments. When she asked the patients why they had never revealed their talents, they often replied that no one had ever asked them. Or some recalled that they had told a nurse about their musical abilities a number of years ago, but nothing had ever come of it.

We found that the staff disagreed about the suitability of various occupational and recreational activities. Some nurses complained particularly of a lack of acceptable activities for older male patients. They believed it was much easier to keep female patients occupied because women are accustomed to such sedentary activities as knitting, making baskets, or weaving rugs. But many nurses adamantly insisted that men who had once spent their days in the fields or at manual labor would not enjoy "women's activities."

At the same time, the hospital administration needed information to guide the recreation and occupational therapy departments in purchasing and allocating equipment—a matter of the utmost practical importance. For example, the hospital recently received money to purchase two pianos. In what part of the hospital could we use them to best advantage? A local mental health association will donate phonograph records to us. What kind of records do patients like? A newsdealer is willing to give his out-of-date magazines to the hospital. What kind of reading material do patients prefer? We found that we had very little information to guide us and decided that an inventory of patients' interests and preferences would yield significant, useful information. Moreover, a survey would help to remove the patients' likes and dislikes from the realm of conjecture.

What Do Patients Really Enjoy?

A ward nurse or an activity therapist interviewed, individually, 307 middle-aged and older patients on male geriatric wards. The questions they asked covered the patients' past interests (What hobbies have you had at any time? What games or instruments have you ever enjoyed playing?); their present activities (What do you now do when you are on the ward? How do you spend your time?); and activities they would like to engage in (Would you like to play checkers, ping-pong, go to movies, etc.?)

We found that 214 patients of the total sample were able to answer at least some of the questions. We do not know how many of the 93 patients who were unable to be interviewed would have responded if we had used more experienced interviewers. But the communicative patients made it possible for the activity nurses to estimate the amount of participation they could expect from these patients.

Our survey list included 36 different items. The most useful information came from responses to questions pertaining to the patients' enjoyment of and interest in specific activities. Most patients preferred listening

*Dr. Sommer became an Assistant Professor of Psychology at the University of Alberta, Edmonton, Canada, in June.

Physical activities are desirable but must be tailored to the capabilities of elderly patients. Even if only a few enjoy a certain activity, it is worth scheduling for their enjoyment.

Instead of trying to set up one general activity on a ward and meeting with lack of enthusiasm and indifference, staff now sets up smaller groups of patients who share an interest in one game.

to music, taking walks, watching movies or TV, and reading. The most unpopular activities were copperwork; flower-making; and active sports such as golf, volleyball, badminton, and tennis. We understood the lack of enthusiasm for sports, since the patients were older men and some of them were bedridden. Essentially, they preferred activities of the passive, spectator variety which involve no pressure to mix with others, permit them to participate or withdraw unobserved, and are not situations in which they must produce something for evaluation.

The largest number of patients—90 per cent of those who were able to be interviewed—preferred listening to music. Their most common response to questions about the types of music they liked was, "Any kind"; 53 patients gave this answer. Twenty-one patients liked western music; 16, old-time music; 10, hymns; 9, popular music; and 9, band music. A sprinkling of them chose polkas, waltzes, classical music, carols, etc.

We also asked the patients whether or not they liked to take part in "sing-songs" on the wards. Eighty-three answered affirmatively. Not many patients were able to state specifically the kinds of songs they liked to sing, but 18 named religious songs; 13, old-time songs; 7, popular songs; and 6, western songs. The others chose miscellaneous categories.

Ninety-four patients answered that at one time or another they had played a musical instrument; of this group, 37 had played the violin; 16, the mouth organ; 14, the guitar; 11, the piano; 6, the cornet; 5, the banjo or mandolin; and 4 each, the trumpet or accordion. Several others had played the trombone, organ, saxophone, or drums. Sixty-nine patients indicated that they would like to play a musical instrument again.

The patients enjoyed reading, even though many complained that their eyes were bad or that they did not have glasses. Fifty-two preferred newspapers; 32, books of various types; 27, magazines; 11, westerns; and 8, religious books. Comics and detective stories received 6 votes each, and sports and love stories, 4 votes each.

This survey has shown us what our older patients like to do. There is no guarantee that the preferred activities are therapeutic, or that the patients are in any physical condition to carry them out for an extended period of time. The occupational therapist, recreational therapist, or nurse must decide the extent of the activities' therapeutic value, but in making this decision they should consider the patients' likes and dislikes. This is important because many therapists are considerably younger than their patients and do not share their social backgrounds.

In an article in the *Canadian Journal of Occupational Therapy*, May 1960, Miss Susan Cross, our former occupational therapist, mentioned how pleased patients were to know that the staff was interested in their opinions. Before the survey, patients often complained that no one ever asked them anything and that they were led from one activity to another without having any say at all. Questionnaires encourage patients to express opinions and help them to overcome feelings of being lost in a large institution.

Making Use of the Survey

After we completed the survey, we wanted to make the results useful to the hospital, especially since we have had considerable experience with survey results that were "interesting" without being helpful. Often, survey data are hidden in manilla folders or laid to rest in the hospital magazine. To avoid the same fate for our survey,

we placed our information in the hands of the ward staff. We believed it was not sufficient to tell a ward supervisor that 18 patients liked to play checkers, 10 liked to play ping-pong, or that 15 wanted to weave rugs. This would not indicate a given patient's particular interests and might suggest a policy of scheduling activities favored by the majority. This policy would be a mistake; even if only three patients want to weave rugs, compared with 20 who want to bowl, weaving rugs might still be beneficial and therapeutic for these three. Therefore, we compiled a list of the patients on each ward who were interested in the various activities. The list, accompanied by a brief note to the supervisor, read, "These are the patients on your ward who like to do woodwork—Mr. Jones, Mr. Smith, and Mr. Brown. These are the patients on your ward who like to play cards—Mr. Davis, Mr. Jones, Mr. Smith, and Mr. Black."

Dormant Skills Revived

The value of the survey to individual patients was dramatized when a bed-patient told the interviewer that he used to play the violin. Although the ward supervisor and his staff were somewhat skeptical, the activity nurse borrowed a violin from the music therapy department and gave it to the patient. To everybody's surprise, he played well. Here was a patient whose talents had been hidden and wasted for 12 years! Such well-learned but dormant skills are of especial value to schizophrenic patients who have difficulty in learning anything new. Because several other patients expressed interest in the violin, extra instruments have been purchased and are being used regularly. For another patient who expressed interest in playing the drums, we found a set that could remain on the ward.

When we noted that reading was a popular activity, we formed several reading groups, and a current affairs discussion group for a group of patients with bad eyesight. At least four patients told the interviewer that they did not read English, and now several foreign-language newspapers have been donated for the benefit of these people.

The great value of the survey has been to convey to everybody the idea that our patients have a wide range of interests. Before the survey, we were unaware of the likes and dislikes of many individuals, and found it frustrating to work with a large number of indifferent and uninterested patients. Where previously one general activity would be scheduled for all patients on a ward, we now attempt to work with smaller groups on different activities.

An important aspect of the study was that it was done entirely by the ward nurses and activity therapists. The idea behind the study came from the activity therapists, but the ward nurses did most of the interviewing. The research department merely helped the nurses to draw up the questionnaire and assisted in tabulating the results. We believe that all of those who were concerned with the study, including the nurses and patients, appreciated the chance to participate in something that was meaningful and beneficial to the hospital activity program. The nurses were especially encouraged by the project and expressed the belief that it was the sort of task they were capable of doing themselves.

Have You Read?

SOME PROBLEMS IN ATTEMPTING TO RELATE TYPES OF THERAPY TO OUTCOME OF MENTAL HOSPITAL ADMISSIONS—by Nelson A. Johnson, M.S.W., *Pennsylvania Psychiatric Quarterly,* No. 1, Winter 1961. During the past decade there has been a rapid, indeed explosive, increase in treatment of mental diseases. Presumably, this has been a good development and a major factor in the phenomenon of decreasing populations in mental hospitals throughout the country.

The matter of measuring the relationship between treatment and rising discharge rates is, however, a complex problem. This paper is a progress report on the approach which Warren State Hospital, Pa., has made to the problem.

THE USE OF DIRECTED WRITING IN PSYCHOTHERAPY—by Harvey Widroe, M.D., and Joan Davidson, M.D., in the May 1961 *Bulletin of the Menninger Clinic.* Under duress some people express themselves more easily in writing than in speaking. This preference for writing can be used in the psychotherapy of a patient who does not speak at all or cannot communicate effectively when he does speak. An unanticipated result of the study reported in this paper was that writing became an important group activity, a way for patients to communicate with one another.

NURSING HOME STANDARDS GUIDE. U.S. Department of Health, Education, and Welfare, Public Health Service. This guide has been prepared to assist state and local licensure agencies and other regulatory or standard-setting groups in instituting or improving laws, regulations, ordinances, or other required standards for the establishment, maintenance, and operation of nursing homes. The term "nursing home," as used in this publication, means a facility or unit, however named, which is designated, staffed, and equipped for the accommodation of individuals not requiring hospital care but needing nursing care and related medical services prescribed by or performed under the direction of persons licensed to provide such care or services in accordance with the laws of the state in which the facility is located. Available: Superintendent of Documents, Government Printing Office, Washington 25, D. C., 45¢.

THE HAPPY COMPANIONS

By A. MARGARET SEYMOUR, O. T. R.
Director of Occupational Therapy
Evansville State Hospital
Evansville, Indiana

MANY AMERICAN houswives have been able to refresh themselves, brighten their homes, and share new ideas with their families because of their membership in Home Demonstration Clubs. These clubs exemplify the aim of the Cooperative Agricultural Extension Service (of which they are a part) to "take the college out to the people" and to "help people help themselves." Programs, conducted in some 66,000 clubs, are helping nearly a million and a half women become better homemakers, better citizens, and, hopefully, leaders in the community.

Carry-over Values of Club

In January 1960, the activity therapy department at Evansville State Hospital added a Home Demonstration Club to its ever-expanding program of special interest groups. This was in line with the hospital staff's conviction that patients should have an opportunity to develop interests and skills by participating in activities that will be available in the community to which they eventually return. Many hospital programs are limited because, individually, they are suitable only for patients whose homes are in rural areas or only for those from urban areas. Home Demonstration Clubs, however, are active in both the country and the city. Consequently, our female patients will be able to continue their club activities, after discharge, in their own communities.

In the Evansville area the County Home Demonstration Association consists of 70 clubs. Its members are interested in their fellow citizens who are being treated for mental illness in the hospital. Miss Jan Armstrong, the local Home Demonstration Agent, made it possible for us to organize "The Happy Companions Club"—a name which the patients selected. The new club's programs, directed by the occupational therapy department, are designed to benefit female convalescent patients.

The county association not only provides leaders to teach in the hospital, but also gives financial assistance—payment for materials, lunch money, and other incidentals—so that members of The Happy Companions can attend leadership meetings in the community. It does the same for the staff member attending the sessions with the patient, and pays individual and club dues.

The Happy Companions Club is listed, without mention of its hospital affiliation, among the 70 local clubs and enjoys the same privileges shared by them. It is represented on the Home Demonstration Council, and its president is installed, along with the presidents of the other clubs, at an impressive candlelight ceremony. Members participate in all local activities and are assimilated readily into the various groups. We are proud that, in June, two of the hospital club members attended a three-day meeting of the State Home Demonstration Conference at Purdue University. Both these people attended simply as members of The Happy Companions Club, and no mention was made of the fact that they were patients in the State Hospital. Said one, on receiving this information, "You mean you are really going to give us a chance?"

The purposes of the hospital club are to: (1) follow the established aims of the association; (2) create interest in participation in community clubs; (3) give patients an opportunity to experience the activities of such clubs; (4) provide an interest for patients during their hospitalization; (5) encourage socialization; and (6) stimulate the members to join a community club after they have been discharged from the hospital.

All of the local clubs have the same programs and activities. The hospital club follows their standard schedule, but has additional programs as well. This expansion

Activities with carry-over values are the best. The hospital club meets weekly, follows outside programs, but offers extra classes.

reflects the staff's belief that the hospital club's members should meet weekly, rather than monthly as the others do. It is difficult for a patient to maintain interest in and enthusiasm for a new activity when she participates in it only once a month. Furthermore, there is a rapid turnover of patients, and, therefore, some of them would miss out on many useful activities if meetings were held only 12 times a year. We are anxious for patients to attend as many meetings as possible so that we can establish positive carryover values. We have found that patients prefer activities in which they can take an active part and those in which they can picture themselves in an ordinary home.

Supplementary Lessons for Hospital Group

However, the weekly meeting presented a problem to the association and to the staff. How could the club obtain leaders and sufficient program material for all of the extra meetings? The association, Miss Armstrong, and the director of occupational therapy arranged for the hospital club to follow the established schedule and to supplement the additional three programs with material previously offered by the council. Association members volunteered to teach the extra lessons, although the hospital's occupational therapy staff conducts some programs, especially those concerning arts and crafts. Outstanding contributions were made by patients who had attended teaching classes in the community, and were able to give club members a special lesson.

Two past presidents of the association work with program leaders in developing lesson outlines, and one of them is present at every meeting. They serve, too, as coordinators between the hospital and the association.

The Home Demonstration Agent and the director of occupational therapy assist members who are leaving the hospital to join Home Demonstration Clubs in their communities. So far as we know, six or eight discharged patients are continuing their membership in the Vanderburgh County clubs. We cannot say for sure how many are still active in the fifteen counties served by the hospital.

All of us sincerely hope that the experience of being a "happy companion" is valuable to our patients and that they will continue to enjoy it when they return to their own communities.

Have You Heard?

INSERVICE TRAINING: The Southern Regional Education Board has received a grant of $384,721 from the National Institute of Mental Health to be used for the inservice training of attendants in institutions for the mentally retarded.

William P. Hurder, M.D., SREB associate director for mental health, has stated that the ultimate purpose of the training project is to improve the care of mentally retarded in institutions by improving living arrangements and by training those who care for institution patients. The grant will cover a period of five years.

FOREIGN NURSE LICENSURE: Problems related to licensure of nurses from other countries continue to present themselves as more nurses are admitted to this country on immigration visas. A subcommittee of the American Nurses' Association Special Committee of State Boards of Nursing, formed to make a detailed study of the problems of licensure of nurses from other countries with a view to standardizing the procedure wherever possible, has worked closely with the ANA Committee on Nursing in International Affairs during the past few years.

A grant from the Rockefeller Foundation made possible a visit from Alice C. Sher, assistant general secretary of the International Council of Nurses. Miss Sher spoke at the Annual Conference of State Boards of Nursing and at the ANA convention in May, 1960, and later visited boards of nursing in California, Florida, Minnesota, New Jersey, New York, and Washington. She explained the assistance available through the ICN in helping boards process applications for licensure of nurses from other countries. This assistance is especially valuable when full school records have been lost in war-torn countries.

Latest figures available on the number of foreign nurses licensed in the U. S. show that in 1958 there were 1,982 nurses from 64 countries licensed in 47 American jurisdictions. Of the 1,982, only 264 were required to write the licensing examination. The largest number licensed from any country—1,027—came from Canada

HILLSIDE HOSPITAL: In May, Volume 1, Number 1 of *Hillside Highlights* was published. The publication is dedicated to sharing the knowledge gained at Hillside Hospital, Glen Oaks, N. Y., and helping the public understand the needs of the mentally ill.

Included in this first issue are the following news items: The United States Public Health Service has notified Lewis L. Robbins, M.D., medical director, that the hospital's application for funds to finance its training program has been approved. Dr. Robbins stated that the grant of $47,000 provides the hospital with the equivalent of five instructors and seven resident stipends in addition to the general practitioner stipends.

Hillside has received accreditation for a full three-year psychiatric residency training program by the Council on Medical Education of the American Medical Association. The change in accreditation from the previously held two-year endorsement results from the many improvements in the training curriculum developed at the hospital during the past two years.

Hospital–Community Endeavors Re-Establish Chronic Patients

By LESLIE NAVRAN, Ph.D.
Coordinator, Hospital-Community Resources
Veterans Administration Hospital
Sepulveda, California

In the summer of 1958, with a supplementary appropriation from Congress, the Veterans Administration Hospital at Sepulveda, California, hired additional staff, concentrated them on an open building housing 164 chronic patients, and worked intensively to return as many of the patients as possible to a stable community adjustment. Such adjustment implied part-time or full-time employment. We created a new position—Coordinator, Hospital-Community Resources—because we intended to concentrate upon involving the community in our total rehabilitation plans.

It is becoming increasingly clear that the treatment of a psychiatric patient is only successfully completed when he has made a satisfactory adjustment in the community, generally as a working citizen. The community, unless it gives fair employment opportunities to the ex-mental hospital patient, is likely to undo the results of the long and costly hospital procedures which led to his discharge. We have seen a significant number of patients leave the hospital in good contact, eager to try to live effectively, only to return three to six months later, defeated, discouraged, and disorganized. "Doc," they say, "You don't know what's going on out there. If you tell an employer that you've come out of a mental hospital, you're dead. They may be nice enough about it while they're seeing you, but you just don't get hired."

Preparation for the "Outside"

In the hospital we try to involve the patient in his own treatment, by giving him responsibility for those things which he can do for himself, thus building his self-esteem and sense of competence. The success we experience is often a measure of the let-down the patient experiences when he returns to the "non-therapeutic community" outside the hospital.

Repeated discussions about this problem during patient-government meetings reveal the patient's own anxieties. "Should you tell an employer you've been a patient in a mental hospital, or should you cover it up, and even lie about it if necessary?" It is clear that patients are in deep conflict because of the negative consequences of either course. A number of them openly dread the prospect of release because the "outside" seems so devoid of opportunity.

It is obvious that we in the hospitals have to develop a new type of relationship with the commuity. A "silent partnership," in which the community accepts the financing of custodial institutions as their sole obligation, is no longer adequate. The people outside have to learn that as the hospital function has changed from custody to treatment, so the community function itself is changing. A "working partnership," in which the community recognizes and assumes its responsibility to help in the final rehabilitation phase of treatment, is needed.

A Three-pronged Approach

We sought advice from experienced counseling psychologists, and finally developed a basic philosophy for our program based on three principles:

1) It is not sufficient merely to educate the public. Instead, we try to involve them as much as possible in our efforts to rehabilitate our patients.

2) We approach potential employers, asking them to give not charity, but an opportunity to a potentially good worker. If an ex-patient is hired, we do not expect the employer to treat him with any special consideration. We make this clear to all patients during ward meetings.

3) We tell patients who are hired to seek help early if pressures develop which might lead to a further breakdown. We tell the employer that free consultation is available through the coordinator if any prob-

lems arise. We call this "the doctrine of mutual support" and it is intended to implement the "working partnership" between hospital and community.

First, we informed other agencies about the program, knowing that if they received secondhand, distorted information they might react coolly toward our plan. The coordinator visited the six nearest branches of the state department of education and explained the program's intent and functions to the manager and veterans' employment representatives in each location. All of these people responded enthusiastically.

Progress is Contagious

We then set up a program of speaking engagements, with neighboring chambers of commerce as the first targets. Soon, however, other groups became interested in our message, and by the end of the first year, we had given 35 talks to service clubs, women's clubs, industrial groups, union councils, and management groups.

In these talks, we make a direct bid to anyone in the audience who wants to try employing patients. We distribute cards before each meeting, and if a card is signed and returned, it constitutes an invitation for the coordinator to pay a call on the employer within the next two weeks to learn details about the job available.

Ward treatment teams then check to see if we have a suitable patient, and if so, we send a summary of his background to the prospective employer. If the employer expresses interest, we tell the patient about the opening for the first time, and if he wishes to apply, we arrange an interview.

At this point, it is strictly up to the employer and the patient to reach an agreement, but the patient can negotiate without having to worry about the employer's attitude toward his illness. During the first 15 months of the program, 61 patients obtained part- or full-time jobs. Of these, approximately 70 per cent were able to work successfully.

Other Programs Develop

During the project, we developed three other major programs to help place patients in the community. One of these we call the Vocational Planning Staff. Local industrialists, as unpaid consultants, visit the hospital on a rotating basis in groups of three. Five veterans' employment representatives from the State Department of Employment also come. Their objective is to help long-term patients, who are within 60 to 90 days of discharge, to make vocational plans in advance. The meetings, which originated as a result of a talk the coordinator gave to the Personnel Industrial Relations Association of San Fernando Valley, are held once a week.

Two patients are presented at each meeting, and the consultants devote one hour to each. First, the psychologist and the social worker give the guests information about the patient's background and hospital adjustment. The visitors then talk with the patient. After he leaves, the group summarizes recommendations for his consideration which the building psychologist passes on to him later.

From November 1958 through June 1959, the visiting consultants interviewed 47 patients. As of August 1959, 26 patients had been discharged, two were to leave soon, seven were on trial visit as Member Employees, and 12 were still in the hospital.

Our original purpose had been to make available to our patients current, authoritative information about employment opportunities, but two additional benefits resulted. First, the morale of all the patients has improved significantly. In the beginning, their attitudes varied from cynicism to hopelessness about their chances for employment on discharge. During the interviews, they displayed indifference, discouragement, or a passive attitude of submitting to yet another exercise to please the staff, but with no real hope that it would yield anything of personal value. However, after the first few vocational interviews, word got around that these visitors were neither "phonies" nor curiosity seekers; they seemed to be interested, warm, and eager to help. These qualities, combined with the practical advice and solid information they offered, gave the patients genuine hope for employment after discharge.

Outsiders Benefit Too

The visitors said that they, too, had benefited from the experience. After the first visit, they invariably expressed surprise at the good behavior and intelligence of our patients. They asked to be invited again, and, through their word-of-mouth accounts, interested others in the project. Today, instead of the original 17 regular consultants, we have about 30. They tell us that, as a result of the experience with our patients, they find themselves dealing more effectively and with less anxiety with people on their payroll who are under severe emotional and mental strain. They are also more objective in handling applications from people who admit they have been mentally ill.

The second major innovation came in the spring of 1959. A businessman, who heard about our program during a Rotary Club meeting wanted information about a patient who had applied to him for work. During a meeting with the coordinator later in the day, he suddenly leaned forward and said, "What you are trying to do is more than one man can handle alone. Why don't you let us help you?" He and his business associates, he declared, had numerous contacts, and would be happy to help patients leaving the hospital to seek work.

A committee of nine Rotarians and the local Veterans Employment Representative visit the hospital once a month. In advance of each meeting we send them written summaries of the work and educational backgrounds of four patients who are ready for immediate release. The committee interviews each patient for 20 minutes and later decides what plan to follow to provide him with leads for employment. Sometimes members of the committee personally offer jobs to the patients. We value this unusual type of assistance, especially because it is being given by the first community group to offer help without being asked to do so.

The third of our new programs is called Project PEP and involves physically as well as mentally handicapped

people. The name was coined from the descriptive phrases: Professionally Evaluated People (with physical handicap) and "Professionally Endorsed Patients"—our own.

This program resulted from our failure to place a patient as a service-station operator. He wanted to work full-time for two months and part-time thereafter, so that he could attend San Fernando Valley State College. The few service stations we checked had no vacancies.

Suddenly it struck us that newspaper advertising might be the solution to bringing potential employers and employees together. Could we persuade the local newspapers to advertise the availability of our recovered patients in their classified columns?

Before we approached the papers, we expanded the idea. We approached the staff of the Van Nuys Department of Employment and asked if they would be interested in a joint endeavor—to publish the availability for employment of physically and mentally handicapped people? After all, why splinter the handicapped into special groups?

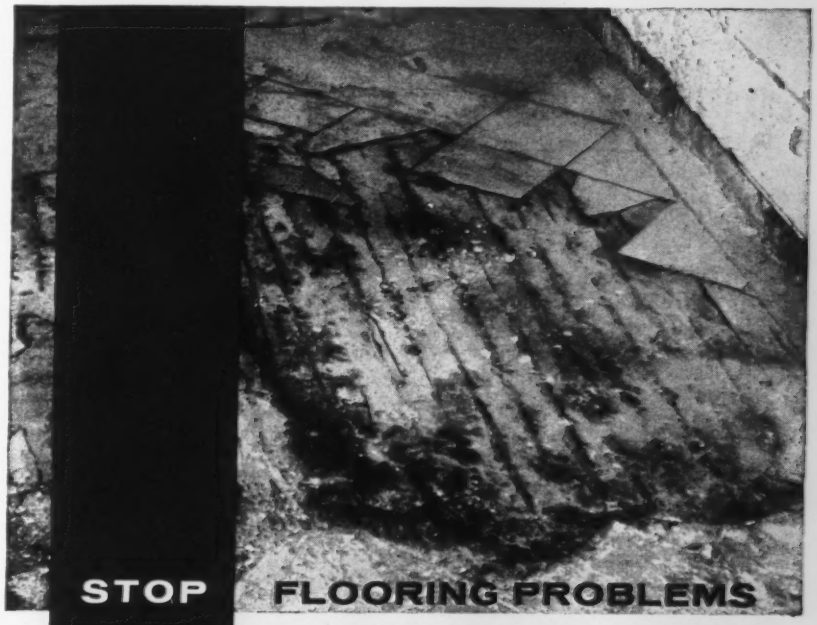
The department accepted our proposal enthusiastically, and together we solicited the help of the newspapers. *The Valley Times* and *The Van Nuys News* donated space for classified ads two columns wide and ten inches high. Fifteen other papers also cooperated from the beginning, and today, 21 participate. The total value of the donated space exceeds $1,000 a week. The hospital and the Department of Employment share the space equally.

The first ads appeared in December 1959. The response of the community has been slow, and we are now trying to draw attention to the ads through radio and television. However, the first 48 ads drew 17 responses, and of these, 7 resulted in placement. The first 48 published for the physically handicapped drew only 8 calls, and no placements resulted. This was most unexpected.

As a result of our work, we feel that the concept of unified efforts of hospital and community is not just an idealist's dream. A significant number of people have cooperated to help re-establish our patients as productive citizens. Our community is not unique, and we believe that most communities would respond to the chance of helping patients help themselves, once they are aware of the need.

One other thing is clear: a job is a necessary but not a sufficient condition for the permanent rehabilitation of patients. Most ex-patients need supportive therapy on an outpatient basis and some help in forming wholesome social relationships. We are trying to develop means of helping in both areas.

Finally, we have learned that treatment and rehabilitation teams must work closely to prepare patients for discharge. Without a continuous flow of high quality referrals, efforts to assist in placement will not succeed. But we are sure that given adequate hospital treatment, plus hospital and community help in re-establishing themselves, the mentally ill can "come back" in numbers which, as yet, have not even been projected. •



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III. Intensive Treatment Centers, Private Psychiatric Hospitals, and other Facilities are needed for those with major Mental Illnesses

Action For Intensive Treatment

By JOHN J. BLASKO, M.D.
Assistant Director Psychiatry and Neurology Service
VA Central Office, Washington, D. C.
Member of 13th M.H.I. Program Committee

"A NATIONAL MENTAL HEALTH PROGRAM should recognize that major mental illness is the core problem and unfinished business of the mental health movement, and that the intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully trained members of the mental health professions." This declaration is made in *Action for Mental Health*, the final report of the Joint Commission on Mental Illness and Health.

This reviewer, however, was unable to find a clear-cut definition of what is meant by the phrase "major mental illness," although on page 260 of the book there is a statement that persons suffering from a major breakdown are those who at the onset of their illness are acutely disturbed and "manifest socially disruptive and catastrophic behavior." Comments on page 86 of the report give the impression that any person with a psychosis has a "major mental illness," and again on page 225, the report states that "a main characteristic of psychosis or any severe mental illness is disordered behavior of some kind."

The above remarks and those which follow illustrate why the Program Committee for the 13th Mental Hospital Institute (October 16-19, 1961, Omaha, Nebraska) hopes that participants will have done some homework by the time they meet to discuss the findings and recommendations of the Joint Commission. This reviewer has deliberately selected areas in the report which may be considered controversial, unclear, or inadequate—major mental illnesses; the care of chronic patients, including seniles; private psychiatric hospitals; and intensive treatment centers. Thus, these comments should not be construed as criticisms of the report itself, which will stand as an important bench mark in the development of mental health programs. Rather they are offered to stimulate thought and discussion about the feasibility, practicality, and implementation of certain recommendations made by the Commission.

The report points out that state hospitals, conceived idealistically to follow the pattern of the few small "moral treatment" hospitals of a century ago, quickly became victims of the community's rejection of persons whose conduct showed gross disorder. Such rejection is practiced at all levels—family, municipal, county, and even professional. Because few individuals could afford long-term care, the "indigent insane" became wards of the states and were at the mercy of both politics and public resistance to increased taxes. Therefore, "major mental illness" may be interpreted as referring to those chronic, long-term psycotics who make up the hard-core of the million and a quarter patients on the books of the nation's hospitals.

No Psychiatric Priority for Long Illnesses

The final report devotes a great deal of attention to the problem of these chronic patients, stating that persons with prolonged mental illnesses are not getting first call upon the services of fully trained members of the mental health profession. Is this finding accurate? Is it a fact that the "private psychiatrist often acts . . . as a transmitting agent in moving patients with acute psychotic breakdowns (major mental illnesses) out of the community and into institutions"?

"The thesis of this final report (page 190), that the lag in treatment of the mentally ill reflects a fundamental pattern of social rejection is nowhere better evidenced than by the continued existence of these 'hospitals' that seem to have no defenders but endure despite all attacks." The report also states that the large majority of state hospitals still have programs that are custodial and punitive—that they need new programs but do not want them. Further criticism is directed at specialization of

**This is the third of a series of articles on Action for Mental Health, the final report of the Joint Commission on Mental Illness and Health. The series is sponsored by the Program Committee for the 13th Mental Hospital Institute, and is intended as orientation material for Institute discussions.*

services and the relative isolation of different mental health workers from one another.

Action for Mental Health borrows from a forthcoming monograph of the total series, *New Perspectives on Mental Patient Care.*[1] "The salient characteristic of treatment of the mentally ill, the Schwartz group concludes, is that some kind of relationship is formed between the patient and the helping person. These relationships can be formed by laymen working individually or in groups, under the guidance of psychiatrists, clinical psychologists, or psychiatric social workers. Helping the mentally ill person is a process of discovering how to work with the particular person at hand. The discovery may be made by selected, trained, nonmedical, mental health workers as well as by psychiatrists. Under our present laws, the responsibility of running mental hospitals rests with the physician. Whether medical or psychiatric training equips one to run a social institution such as a mental hospital in the most effective and therapeutic manner should be a question to be explored rather than an assumption that is taken for granted."

Nobody, probably, will disagree that the formation of "therapeutic relationships" in a hospital of several thousand beds is difficult, but Institute participants will certainly have some sharp comments to make upon the suitability of the psychiatrist as administrator, and whether "laymen" should be permitted to operate "therapeutically," even under supervision.

Where Are Geriatrics to Go?

The Commission's final report is relatively silent about the aged psychiatric patient, except to indicate that senile psychotics account for the highest number of admissions to state hospitals, and that these patients do not especially benefit from the tranquilizing drugs. The report recommends that "no future state hospitals of more than 1,000 beds should be built and not one patient should be added to an existing mental hospital already housing 1,000 or more patients." Presumably, then, some other facility must be found for these elderly patients.

Is a 1,000-bed hospital too large? In May 1851, at a Philadelphia meeting, the Association of Medical Superintendents of American Institutions for the Insane, (now the American Psychiatric Association) unanimously passed a resolution that the largest number of patients who can be treated with propriety in a hospital is 250, while 200 is a preferable maximum. The same group passed another unanimous resolution that "every hospital having provision for 200 or more patients should have in it at least 8 distinct wards for each sex making 16 classes in the entire establishment."

In 1866, however, in Washington, D. C., a vote of a bare majority of the members then present decided that under certain circumstances a hospital "might be enlarged to the extent of accommodating 600 patients, embracing the usual proportion of curable and incurable insane, in a particular community."

Dr. Thomas S. Kirkbride, one of the original thirteen founding superintendents, in commenting on this unfortunate change in the official attitude of the Association, pointed out that the words "might be enlarged" were significant, but admitted that it is often easier to secure appropriations for additions to an existing hospital than for the erection of a new one. He stuck to his guns, however, and had no hesitation in continuing to support the maximum of 250 beds, originally recommended by the Association.

But public mental hospitals were eventually developed and operated with almost complete disregard for the sound resolutions and wise recommendations of the original members of the Association of Medical Superintendents of American Institutions for the Insane.

Intensive Care Hospitals Recommended

Now, 110 years later, the Joint Commission recommends that intensive care units, not to exceed 1,000 beds and with a one-to-one patient-staff ratio should be established for psychiatric patients. These centers would admit patients with major mental illnesses in the acute stage and chronically ill patients with a good prognosis. Competent psychiatrists, trained in hospital administration, would head the centers; they should be thoroughly experienced in and prepared to use modern psychological, social, and physical methods of treatment.

If such 1,000 bed units are to be constructed, we should at least remember Dr. Kirkbride's recommendation as to the size of wards; "Of the quiet, or supposed incurable demented, as many as twenty could be taken care of in one ward, with quite as much or even more facility than less than half that number that are highly excited."[2] The need for small wards must be stressed.

The report also states that the existing staff pattern in public mental hospitals is inadequate to provide long-term care to persons suffering from chronic diseases. Its recommendation that "not one more patient should be added to existing mental hospitals already housing 1,000 or more patients" would be most difficult to implement, and its further recommendation—to convert these large hospitals into chronic disease hospitals for all illnesses, including mental illness—even more difficult.

A chronic disease hospital of over 1,000 beds could be operated by the average, well-trained lay administrator, says the report, in a manner that would encourage relearning, group living, and other techniques of socialization, and at the same time effect a saving of scarce manpower. But who would be admitted to such hospitals? Would their beds be limited to the indigent? Is the commission's suggestion of prepayment and subsidy plans the answer? What would happen to the traditional system of American medical practice?

When the A.P.A. was founded in 1844, even the 250-bed psychiatric hospital was operated on the basis of complete separation of the acutely ill from the chronically ill patients. While it was considered that the acutely ill needed medical treatment like the "ordinary

[1] *Schwartz, M. S., Charlotte G. Schwartz, M. G. Field, E. G. Mishler, S. S. Olshansky, J. R. Pitts, Rhona Rapoport, and W. T. Vaughan, Jr.*

[2] Kirkbride, Thomas S.: *On the Construction, Organization and General Arrangements of Hospitals for the Insane,* 1859.

sick," the chronically ill patient was held to be incurable, needing only "moral treatment," which did not include specific medical treatment. Would the relegation of long-term patients to a chronic-disease hospital imply that medical treatment and phychiatric treatment for these patients is of secondary importance? Would we be saying, in effect, that these patients are "hopeless"?

What should be the response of the average public mental hospital to the findings (also drawn from the forthcoming Schwartz report) included on pages 174 and 175 of the final report? Is it true that "the superintendent of a state mental hospital has little room for administrative maneuver"? That "the administrator's freedom to release patients to the community is . . . more apparent than real?" That "the easiest solution . . . is to develop safe programs of patient care and treatment that pose little risk of incidents" because "apparently, administrators in the past have preferred to have custodially-oriented institutions with safe programs rather than active treatment centers since the latter presuppose and entail larger risks"?

State Hospitals Discharge Many

Despite these thoroughly negative aspects, the report says that "the state hospital is not, and indeed never has been, quite the end of the road or point of no return that many people believe it to be. The discharge rates vary considerably, but from 40 to 75 per cent of patients are released within one year after admission . . ."

In contrast, on page 177, the report has high praise for the private psychiatric hospitals, at the same time stating: "They do not, however, play a significant role in the care of the nation's mental patient population when viewed in numbers of cases cared for."

The numbers game, however, is not the best way to evaluate the private psychiatric hospital's contribution to the treatment of the mentally ill. Early private hospitals originated "moral treatment"; more recently they were among the first to achieve intensive treatment of the mentally ill and an early return of the patient to his home.

What is the future of specialty psychiatric hospitals, especially for private ones? Recently, their advantages and disadvantages in relation to psychiatric units in general hospitals have been aired. Desirable attitudes and milieu are said to be more easily produced in the psychiatric hospitals, while the relationship of psychiatry to other medical specialties is ultimately healthier in the general hospital unit. Will these units replace the specialty hospital, at least for short-term treatment? Can the patient suffering from long-term mental illness be treated in such units?

The Mental Health Study recommends categorically that every community general hospital should provide either a psychiatric unit or psychiatric beds, adding that "definitive care for patients with major mental illness should be given if possible, or for as long as possible, in a psychiatric unit of a general hospital." Those requiring long-term treatment, the report recommends, should receive it "in a specialized mental hospital organized as an intensive psychiatric treatment center." •

MORE ABOUT THE
13TH MENTAL HOSPITAL INSTITUTE
—OMAHA

Main Theme:

NEW PERSPECTIVES ON MENTAL PATIENT CARE

THE PRELIMINARY PROGRAMS and registration forms for the 13th Mental Hospital Institute, to be held October 16-19, 1961, at Omaha, Nebraska, were mailed in the middle of June, and hospitals will have received sufficient copies for staff members who plan to attend.

Once again, participants will be working in groups—five groups of between 40 and 50 people, and fifteen of between 15 and 20 people. However, all participants will lunch together, and the Program Committee has allowed sufficient time between sessions to enable everyone to see the scientific and commercial exhibits.

As soon as we receive your registration form we will assign you to one of the discussion groups listed in the preliminary program. You will be notified of the name of your leader, your topic, and the size of your group, and will also receive a paper-bound copy of *Action for Mental Health*, the Final Report of the Joint Commission on Mental Illness and Health. This report supplied to Mental Hospital Services through the courtesy of Jack R. Ewalt, M.D., the Director, is the document upon which the main theme of the Institute is based. The Program Committee has formulated certain specific topics from the Report for discussion.

As in 1960, related professional groups will hold their meetings in the two days immediately preceding the start of the plenary sessions—Sunday, October 15th, and Monday, October 16th. The professional meetings announced so far are listed on page 27 of this issue.

On Monday afternoon there will be two hospital tours, each starting from the headquarters hotel at 1 p.m. Tour No. 1 goes to St. Bernard's Hospital, Council Bluffs, and Richard Young Memorial Hospital (Lutheran) in Omaha. Tour No. 2 includes Our Lady of Victory (the psychiatric wing of St. Joseph's Hospital) and the Veterans Administration Hospital, Omaha. Both tours will

OCTOBER 16-19, 1961
HOTEL SHERATON-FONTENELLE
NEBRASKA

A Consideration of "Action for Mental Health," the Final Report of the Joint Commission on Mental Illness and Health

meet later at the Nebraska Psychiatric Institute, where Dr. Cecil Wittson, Chairman of the Local Arrangements Committee, has arranged to give a demonstration of the much publicized closed-circuit-television education program.

As usual, there will be a film program. This year it is to be planned and operated by the Mental Health Materials Center of New York, under the direction of Mr. Alex Sareyan. At 7:15 each morning, new mental health films will be screened. The now-traditional coffee and doughnuts will be served. There also will be screenings at 4:30 on Tuesday and Wednesday afternoons for movie fans whose diurnal temperature cycle doesn't rise until late in the afternoon.

Tentative plans for the wives of delegates include a fashion show and a luncheon. Each registrant and each of the visiting ladies will be presented with a special directory, being printed by the Nebraska Psychiatric Institute under the direction of the Ladies' Committee, which will contain lists of good shops, theaters and the current productions, places of local interest, and other useful information about the area. Local District Branch members, members of the staff of N.P.I., and their wives will act as hosts and hostesses at a cocktail party on Monday evening, October 16, to be given by Mutual of Omaha for all registrants and their wives.

The Annual Banquet is to be on Wednesday evening instead of Tuesday. The cocktail hour has been extended to enable the Medical Director to see and greet as many people as possible. The dinner will be followed by the presentation of the 1961 Achievement Awards, the presentation of Remotivation Pins, and the presidential address by Walter E. Barton, M.D., the title of which will be "Vanishing Americans: Mental Hospital Administrators and Commissioners."

Other Professional Meetings

SUNDAY, OCTOBER 15

10 a.m.-5 p.m.

AMERICAN SOCIETY OF MENTAL HOSPITAL ADMINISTRATORS
Mr. Delbert C. Mesner
Business Administrator
Nebraska Psychiatric Institute
602 S. 44th Ave., Omaha, Neb.

1 p.m.-5 p.m.

DIRECTORS OF VOLUNTEERS
Mrs. Miriam Karlins
State Volunteer Services Coordinator
Department of Public Welfare
St. Paul, Minn.

1:30 p.m.-4 p.m.

PSYCHIATRIC NURSES
Miss Johanna DeVries, R.N.
Mental Health Nurse Consultant
Community Services Division
602 S. 44th Ave., Omaha, Neb.

MONDAY, OCTOBER 16

9 a.m.-5 p.m.

DIRECTORS OF VOLUNTEERS

9 a.m.-5 p.m.

MENTAL HEALTH ASSOCIATION STAFF COUNCIL
Mr. Joseph R. Brown, Pres.
Mental Health Association Staff Council
615 N. Alabama St., #334
Indianapolis, Ind.

9 a.m.-5 p.m.

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
Harold L. McPheeters, M.D., Comnr.
Department of Mental Health
Louisville, Ky.

9:30 a.m.-5 p.m.

PSYCHIATRIC NURSES

9:30 a.m.-4:30 p.m.

AMERICAN SOCIETY OF MENTAL HOSPITAL BUSINESS ADMINISTRATORS

6:30 p.m.
Annual Banquet of ASMHBA

1 p.m.-5 p.m.

"HOW THE FINAL REPORT OF THE JOINT COMMISSION WILL AFFECT MEDICAL SUPERINTENDENTS OF PUBLIC MENTAL HOSPITALS
Archie Crandell, M.D., Supt.
New Jersey State Hospital
Greystone Park, N. J.

"I Didn't Know the Person in the Next Room, but..."

The Heartening Response of Patients to an Experiment in Dual Purpose Remotivation

By GLADYS ADAMS, L.P.N.
Supervisor, Polk County Area
Clarinda Mental Health Institute, Iowa

IN MARCH 1959, the Clarinda Mental Health Institute initiated a remotivation program which followed the 30-hour Philadelphia technique.[1] The program was a heartening success. Patients, obviously benefiting from it, were rediscovering the value of friends and were remembering or relearning everyday life experiences.

"We were on the same ward for months," one patient said, "and I didn't know the person in the next room; but in the group we learned about each other and that we had interests in common to talk about." Another was pleased to observe that "knowing the other person's likes and dislikes created a better understanding between us."

Patients Trained as Group Leaders

Interest and enthusiasm ran high. Unfortunately, however, as with so many other mental hospital programs, time and personnel were too limited to carry on the work so well begun. One day, with the assistant superintendent and the director of nursing, several of us discussed these problems and how they threatened to affect the program's beneficial results. The superintendent and director asked why we could not enlarge the program and spread its benefits among more people by teaching patients the remotivation technique and having them serve as group leaders.

This suggestion was the only impetus we needed to start the patient-training program. Not many changes were necessary. We already had adequate physical facilities—classrooms and other resources that had been used to train nurses and aides. The material these personnel had used would do perfectly well for the patient-trainees. We had only to make a few changes in terminology in the *Remotivation Technique Manual*, such as substituting "individual" and "group leader" for "patient" or "patients."

We selected patients for the course by interviewing interested volunteers from the 46 existing, conventional remotivation groups. The hospitalization period for these patients varied from a few weeks to many years, and their physicians made recommendations that aided us in the screening process.

On September 23, 1959, nine patients, four women and five men, met in the remotivation room for their first two and one-half hour meeting. These potential group leaders continued to meet three times a week for a total of 30 hours. Five completed the course, one was discharged from the hospital, and three others were unable to finish because of poor health. In November, the assistant superintendent and director of nursing presented certificates to the five newly trained group leaders. Afterward, the graduates attended a party held in their honor at the Friendship Center (a volunteer social club for patients).

One Patient Carries On

What happened to these group leaders after graduation? One was transferred to a veterans' hospital and one was discharged. Two others, before their release from the hospital, actively led groups. One of these, a woman who had been hospitalized for many years, is now employed in a home where she is caring for children. Once, when I paid her a visit, she commented, "What I learned while working with groups in remotivation has been very helpful in understanding children and their need to make their own decisions."

Today, we have one graduate of the training program left who is holding weekly meetings with heterosexual groups. Although she welcomes staff members who visit the group, she is not dependent on their help. It is difficult to say who derives the most benefit from her work—she, who has had lengthy hospitalization, or the members of the group she is remotivating. This leader visits the hospital library every day and is always on the alert for new material to present to her group. The group members continue to show interest, be responsive, and look forward to their meetings.

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[1] *Introduced by Dorothy Hoskins Smith in the Philadelphia (Pa.) State Hospital. The technique consists of a series of informal meetings of selected patients. An attendant initiates purely objective conversation on simple, everyday subjects. These conversations give even the most regressed patients an opportunity to share enjoyment with other people. See* MENTAL HOSPITALS, *January 1958, pp. 14-15, for a full discussion of the technique. Training, financed by the Smith Kline and French Foundation, is carried out in various hospitals under the sponsorship of the APA-SKF Remotivation Project.*

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CD-960

Patient Government: Development and Outgrowths

By ALADAR E. MAKO, M.D.
Clinical Director
Fairhill Psychiatric Hospital
Cleveland, Ohio

PATIENT GOVERNMENT as a form of treatment has had limited use, and its structure usually has been clearly defined before it has been placed into operation. However, at the Fairhill Psychiatric Hospital, its development was a gradual and nonstructured process, accompanied by many interesting outgrowths. This article will describe the evolution of patient government as a therapeutic technique on two of the hospital's wards and discuss some of its interesting derivatives.

Fairhill opened in March 1959. The superintendent, Ewing H. Crawfis, M.D., stated that it would function as a combination hospital and home, employing the advantages of both. In addition, he asked that a daily ward meeting be held, to include both patients and personnel.

At present the hospital has two male and two female closed wards and one heterosexual open ward. The writer, until recently, had charge of one male ward and was administrator of the mixed ward. It was on the male ward that patient government developed gradually and significantly.

A daily schedule, posted on the patients' bulletin board, was used initially to outline regularly scheduled activities to fill the patients' daytime hours; evening recreational activities were voluntary. As a result, there were rarely any patients on the ward during the day; thus, no patient was allowed to regress or isolate himself on the ward. The 8:30 a.m. daily ward meeting followed a regular routine. Patients openly discussed interpersonal problems, questions concerning medication and hospital rules, and topics such as homosexuality or relations with the opposite sex. Attending personnel—nurses, psychologists, social workers, recreational and occupational therapists, and the chaplain—made comments. The head nurse read the list of appointments for the day (X-ray, psychology, etc.) and recorded the names of patients requesting to see the psychiatrist privately.

A patient acted as an unofficial leader for the patient-group until someone suggested that there was a need for an official spokesman. The patients voted to have such a "leader," and decided that he would be selected for a three-week period on a seniority basis, i.e., date of admission to the ward. Whenever the ward psychiatrist was unable to remain for a meeting, he turned it over to the leader.

Now, the leader, following parliamentary rules, presides over all meetings, and the ward psychiatrist is regarded as just another member. Patients are free to invite members of the various departments to clarify their problems. If a patient brings up a problem concerning the food or how it is served, the leader requests the head nurse to invite the dietitian to discuss the problem. Likewise, the business manager has addressed the group in regard to financial problems.

At first, the personnel expressed anxiety about the delegation of authority and status to the patient-group and its leader. However, their anxiety dissipated as the meetings increased cooperative attitudes and decreased acting-out tendencies on the part of the patients.

Nevertheless, because of occasional disturbed behavior, the patients soon realized that some corrective discipline was necessary. They voted to have a Grievance and Disciplinary Committee, consisting of three elected patients, one serving as chairman. At first, the

committee seemed incapable of functioning when it received complaints—perhaps because of fear of exercising authority, unwillingness to censure fellow patients, and indecision as to the type of action it should follow. Therefore, the head nurse of the ward became a standing consulting member. This action resulted in an extremely well-functioning committee.

The committee hears grievances and writes recommendations for disciplinary action to be taken by the ward psychiatrist. For example:

> "The disciplinary committee feels that Mr. N..... should only be warned at this time about his emotions causing him to pick up a chair and threaten Mr. S..... who made very uncalled for remarks against Mr. N..... In regard to Mr. S..... the disciplinary committee has decided to take away Mr. S.....'s privileges for an indefinite period. However, we, the committee, have decided he may attend the occupational therapy activities. (signed) C..... M....., Chairman, Disciplinary Committee."

The ward psychiatrist invariably carries out the committee's recommendations; corrective discipline is very well received, and the committee meets with remarkable infrequency.

Expanding Committee System

Then the patients formed a Rules Committee, consisting of three elected members. This committee is allowed a relatively free hand as long as its decisions do not interfere with hospital policy. One of the problems it tackled was that on visiting days relatives and friends could visit all areas of the ward, causing embarrassment to some patients. The Rules Committee decided that visitors on the ward were to be allowed only in the dayroom and ward kitchen. This ruling was accepted without comment by patients, ward personnel, and visitors.

When hospital policies on patient privileges were determined and clarified, a Privilege Committee, consisting of three patients and the ward psychiatrist, was established. The psychiatrist appointed himself chairman, probably because of his anxiety about permitting patients to be solely responsible for determining privileges. This committee meets weekly to decide upon building, ground, or off-ground privileges. A particular privilege is granted to a patient if three of the four members agree, i.e., if the three patients agree and the ward psychiatrist does not, although split votes of this kind are rare.

There is a Welcoming Committee, consisting of a member of each of the three standing committees, to explain patient government to newly admitted patients. Recently, a Week-End Committee also was elected to set up a program of voluntary activities for patients who complained of inactivity during week-ends.

The rotating leadership of ward meetings and the number of committees permit each patient to function at least once as an authority figure. Sibling rivalry and authority-figure problems are interpreted, when possible, to the individuals concerned and to the group.

There has been a most interesting outgrowth of patient government. Patients began to complain of irritation and boredom with the monotony of the daily routine of scheduled activities. As an antidote and an experiment, they decided that for one day of the week they would schedule their own ward activities. (From the psychiatric viewpoint, the experiment was to determine the capacity of mental patients to initiate, plan, and execute such a program.) For this purpose, the patients elected a Special Activities Committee and voted to abide by its decisions. This committee readily took up the challenge. It initiated various sports activities and contacted the Ohio Bell Telephone Company which supplied a projector and projectionist to show films. However, because of many problems—limited finances, difficulty in obtaining transportation, interdepartmental conflicts, shortage of escorts for patients—this experiment was short-lived.

A Productive Failure

Nevertheless, this failure led to another interesting consequence of patient government. In the hospital's early days, off-ground privileges had little meaning because they were given only during periods when there were no scheduled activities. But the hospital administration believed that such privileges should convey status and have concrete significance. Therefore, when the Privilege Committee grants these rights now, it does so with the understanding that the patient receiving them will join the authoritatively structured "Off-Ground Privilege Group" and abide by its rules. At first, these rules were ill-defined, but as the group's experience increased and it became more conscious of its identity, it changed its name to the "Fairhill AWL (absent with leave) Club." The membership varies from 10 to 17 patients. When a club member loses his membership, either by his own wish or by vote of the others, he automatically loses his off-ground privileges.

The club has its own stationery, maintains contact with its discharged members, and has written its own constitution without aid from hospital personnel. Its dual object is for its members to become better adjusted to society and thereby to improve the public's understanding of mental illness. Its activities include excursions throughout the Cleveland area and participation in group activities such as seeing films and attending lectures. Patients in the club are on their own; they initiate, plan, finance, and execute all of their activities without assistance, unless it is requested. Assistance was given only once when the club borrowed twenty-five dollars from the hospital.

The activity, initiative, and ability demonstrated by this group has been most amazing. On members' "days off," they leave the hospital unescorted for a few hours or for the entire day. Their activities have been myriad. They have toured industrial plants, local newspaper plants, and museums; taken boat trips; attended movies (usually with free admission after correspondence with the theater managers); attended sports events and lectures with complimentary tickets obtained by their own efforts; established excellent relations with the YMCA for swimming and calisthenics; participated on a local television program (it was a decided boost to patient

and personnel morale to see these club members on the TV screen); and visited the Cuyahoga County Court House to see court in session. During these excursions, there has not been a single instance of conflict or abnormal behavior. Club members maintain good public relations by sending thank-you letters on club stationery and by their general excellent behavior.

The club enjoys an exceptionally fruitful relationship with the Cleveland Public Library. It is on the library's mailing list and frequently obtains films from the Main Library for showing on the ward. Films on mental health are shown each week to patients from all wards and to head nurses and other personnel. Afterwards the head nurses and patients return to their wards to discuss the films, which have been so well received by the patients that they have been adopted by the nursing department as a medium for teaching mental health. Thus, a patient-project has affected the hospital policy in respect to treatment.

Developments in New Directions

Patient government on the heterosexual open ward was developed in a different manner because, originally, its patients were apathetic and showed minimal spontaneity toward the project. The patients, apparently showing resentment toward the structured controls that existed on the closed male ward, decided not to have committees, but only a "host and hostess" elected for two-week periods.

During one meeting, a number of patients expressed boredom with existing patient activities, which were similar to those on the closed wards. The administrator suggested that the patients attempt to schedule their own activities for the entire week. An energetic head nurse helped them to evolve a "Patients' Preference Program." This permits each patient to plan his hourly program for two weeks. All patients are urged to devise new programs in which they may be interested. These include a humor hour, discussions and didactic reading on mental health led by the head nurse, sessions on personal hygiene, charades (which are changing into a form of psychodrama), special sewing classes, and reading and pronunciation classes.

As a result, the ward atmosphere has been reversed dramatically. There is little lethargy; patients are cheerful and interested in carrying through their own programs. The depressed patients are less so because their self-esteem is being elevated; withdrawn patients are more verbal and spontaneous. There is no acting out and the social graces are more evident among the patients.

On one occasion, the patients devoted their humor hour to a "This Is Your Life" program in honor of the head nurse. The program not only delighted the nurse, but also demonstrated the value of patient government in re-educating and resocializing the patients.

Prognostic job testing is another technique used in resocialization. Patients who want to seek work are permitted to do so. More reluctant patients are urged to look for work and told that their discharge may depend upon their abilities to obtain and hold jobs, especially if they have not worked for months or years prior to admission. The working patient may remain in the hospital for periods varying from a few weeks to two months, depending upon the severity of his readjustment problems.

Results of Self Government

It is difficult to assess the precise effect of patient government and its outgrowths, especially when all other types of therapy are used simultaneously: chemotherapy, individual psychotherapy, occupational and recreational therapy, hospital milieu, etc. (To date, no electric shock has been given.) But in the writer's experience, patient government and its derivatives help the patients to reach a higher degree of re-education, resocialization, and maturation of personality—and at a more rapid rate. It also affords excellent group support for the stresses the patient experiences during individual therapy.

The patients themselves frequently make a meaningful statement about patient government to recently admitted depressed, hostile, or anxious patients: "A few weeks here and you will change; I used to be just like you." This statement reflects the tolerance and sympathy existing between patients in this setting. These attitudes also characterize relationships between patients and personnel.

The employment of the techniques of patient government, patient clubs, and patient-preference programs brings about the reorganization and exercise of interpersonal relationships on a wider range, develops initiative, elevates group and individual self-esteem, neutralizes effectively the stigma of hospitalization, develops acceptable feelings of group responsibility, and counteracts overdependency. Patients become more aware of necessary interdependence between human beings. Reality does not appear as threatening to them, and in many cases it actually becomes pleasurable.

The patient often attributes a large share of his improvement to his own efforts, probably with some justification. He discovers his untapped capabilities. He recognizes faulty family relationships and often observes this recognition by stating that, after discharge, he intends to promote mental health activities. Thus, he learns that he has worth as an individual, that he is able to feel secure and to engage in group activities. He develops self-knowledge and rarely demands discharge, but readily accepts it when it is recommended. After discharge, patients frequently make social visits to the hospital.

Patient government and its outgrowths in this hospital have proved to be effective therapeutic means of preventing overdependency, regression, and excessive assuming of ego functions by the hospital. The extent of the release of acceptable ego functions of mental patients in this setting has been a revelation to hospital personnel.

The author wishes to express his gratitude to Dr. E. H. Crawfis, superintendent, and Dr. I. N. Perr, assistant superintendent, for their cooperation in the experimental ward programs and for reviewing this article.

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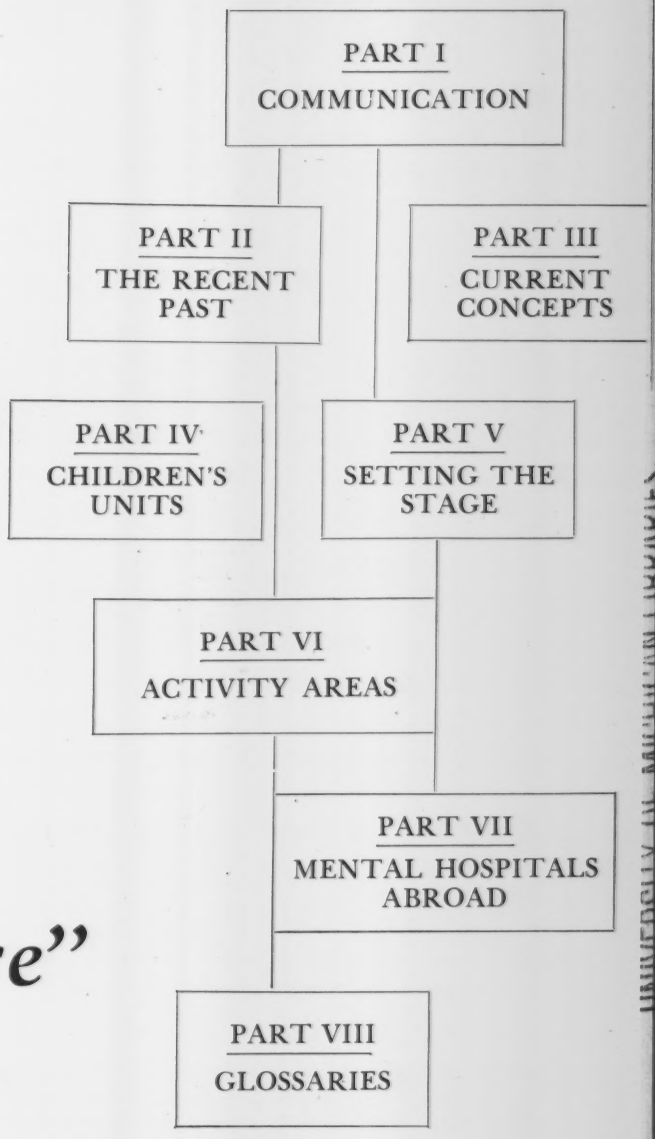

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*Letter from a Patient's Son**

I WONDER *if you would please do me a very big favor and see that my dad gets the letter that I have enclosed herein. It is the first letter that I have ever wrote my dad and no doubt the first one from the family in a number of years.*

I was only three years old when he was put in the hospital about 34 years ago and when I was old enough to see him he never seemed to want anything to do with the family. Then a few years back the doctor in charge told us it would be better if we didn't see my dad in person anymore as it would upset him so much after we left him. We then stopped coming to see him anymore and I thought he would never be any better and gave up all hope until last week when I heard he had really changed for the better so I went right over to see him.

They told me over there that for years he never would talk to anyone, that he would spend all his time by himself, that he wouldn't even accept a cigarette from anyone. So last Thursday I brought him over a carton of cigarettes and after I talked to him a while he did accept the cigarettes. The nurse in the ward at the time said that was the first time he had smiled.

My dad cannot speak in a loud voice; he can only talk in a whisper and you have to put your ear next to his mouth to hear him at all, which no doubt is caused by him not talking all these years.

Last Sunday we took my dad for a ride for the first time. I showed him the place where he used to live but he seemed to show no interest at all. He seemed to feel that he couldn't trust us, that he still wasn't sure I was his son.

Then I took him to my sister's home for dinner. My wife and 10 year old daughter was there, also my sister's daughter and her 1½ year old baby girl. At first my dad seemed to be so surprised at the things in the house. Then we showed him pictures of my sister and myself when we was real small, also of himself with us. Then a big change came over him and for the first time I think he really believed us and trusted us.

Then the little baby woke up and I wished you could of seen my dad. He was so happy to see that baby and we was so surprised when he went over and picked her up off the floor and held her in his arms and kissed her. Then some tears ran down his cheeks and you could see he was so very happy, as that no doubt was the first time he had held a baby in his arms since the time my sister and myself were little, which was many years ago. Then my ten year old daughter went over and kissed him and sat on his lap and I don't think there was any man ever any more content and happy than he was then.

We started talking to him and do you know he told us where he used to work, where he was born, where he lived, and even the house numbers. He told us how he had suffered all these years and that he no longer trusted anyone as he had been hurt so much, and that he believed that no one cared for him anymore, but that now for the first time he really believed that I was his son and my sister was his daughter. He talked all the rest of the day about so many things. I asked him if he would like to see our boat in the boathouse and he said very much. I showed him the boat and he said someday he would like to ride in it. Then on the way back to the house he seen my dog who came over and wanted to play with him. Well, you ought to see the fuss my dad made over that dog as though that was the first dog he had touched in years.

We went in and had dinner. He was so polite and had such good manners and he even went for a second helping. My sister fixed him some ice cream with syrup and he gave her a kiss and said, "God bless you all."

We showed him some moving pictures of the family and took moving pictures of him, and I wish you could of seen how happy he was with all of this.

I told him it was time to take him back even though I wanted him to stay longer and he said that he understood, that he had to go back. Then I asked him if he wanted to come again Sunday and he said he would be so happy and pleased if we did get him.

On the way back to the hospital you ought to see the interest he took in the towns we went through and you could see he remembered the town where he used to live. My daughter got on his lap and fell to sleep on his shoulder and he held and patted her hand the rest of the way back and I know my dad had one of the happiest days in a very long time.

Sir, I know you people are very busy over there and that what I am writing is of no interest to you, but I am so happy that God has brought Dad and myself together again after all these years that I had to write you and thank all of you for the help you have given him.

I know he is a long way from perfect yet but I believe if we show that we still care for him and that we love him we can give him some happiness for the few remaining years of his life.

That is why I'm asking for your help. My dad believes that anything we give him will be taken from him, such as the carton of cigarettes we gave him. He said he never seen them after we left. I know that you cannot give him all them cigarettes, and that for years he wouldn't accept anything from no one but he seems to distrust everyone over there, like he said if I wrote him he would never get our letter and that if he wrote they wouldn't mail his letter. I know that isn't true but maybe if someone would give him my letter and tell him it wasn't going to be taken from him, and if someone could try and get him to write me a letter he would learn to have trust in people again.

Sir, again I want to thank you and please try and understand that after all these years I still might know my father.

**Received by L. V. Lopez, M.D., Manager, Veterans Administration Hospital, Canandaigua, New York, and forwarded to MENTAL HOSPITALS.*

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BEHAVIOR PATTERNS

Observed in Occupational Therapy

By ARTHUR N. GABRIEL, Captain U.S.A.F., M.C.*
RUTH SHAMAH
Chief Occupational Therapist
and LOUIS LINN, M.D.
Associate Attending Psychiatrist
Department of Psychiatry
Mount Sinai Hospital
New York, N. Y.

OCCUPATIONAL THERAPY may take many forms in the inpatient treatment of the mentally ill. At Mount Sinai Hospital, the department of psychiatry has evolved a program which, as far as possible, is consistently unstructured. Our procedure, in addition to certain therapeutic advantages, proved to be a useful research technique; the completion of a patient's occupational therapy project provides an objective measure, very like a fever chart, which permits us to follow the resolution of his conflicts and dependency needs from the time of admission until discharge from the aftercare clinic.

The occupational therapist greets all new patients on the ward as part of their admission routine; she invites each one to join the other patients in the occupational therapy shop but applies no pressure. Out of 238 patients admitted in two years, 130 undertook occupational therapy, voluntarily, for a total of 1,200 hours.

Work Changes Reflect Emotional Movement

When new patients go to the shop, they are invited to select a project from a prominently displayed chart. No one attempts to persuade them to choose projects which are "useful" or to make saleable objects, and they are permitted to work pretty much as they please. The occupational therapist and her assistants do not correct technical errors unless they pose a problem and the patient requests assistance. This unstructured program enables us to assume reasonably that changes in the nature of the patient's work reflect changes that are taking place in his psychiatric condition.

The occupational therapist keeps all the patients' productions unless an individual patient deliberately chooses to destroy his own, in which case she records the incident. Once a week the entire staff meets in the OT shop for a conference. At this time, the occupational therapist displays the week's work, and staff members discuss the productions in terms of what they already know about each patient from their own contact with him.

In time, we began to recognize that certain patterns of work were being repeated, and, ultimately, we were able to predict their appearance. One of the first work patterns which we were able to identify reliably we labeled "The Weaning Reaction." The following example illustrates it:

> The patient was a single white girl of 19 with an IQ of 145 and considerable artistic talent. She was depressed and had been admitted to the hospital following threats of suicide. Her diagnosis was passive-aggressive personality, passive-dependent type. A notable factor in her history was a stormy, ambivalent attachment to her mother.
>
> After discharge to a girls' residence, she continued psychotherapy in the aftercare clinic. We noted that she had left behind her several interesting paintings and pieces of sculpture in various stages of completion. She usually visited the shop during her clinic visits and continued to work on her various projects. As she improved, she completed all of her artistic undertakings. Just before she was discharged, she collected all of her finished works and took them with her.

Following the clue provided by this girl, we observed that it was characteristic of discharged patients to leave uncompleted work in the shop. The only exceptions were found exclusively among patients transferred to another hospital for long-term care. Those discharged to the community returned to the occupational therapy shop in large numbers as soon as they realized that such post-discharge visits would be welcomed. We found that we could predict that a patient was ready to leave the aftercare clinic when he completed his work and took it home with him. Patients would return a year or more after discharge to claim objects which they had left behind as a token of their continuing need of us.

O. T. Product May Symbolize Support

In addition, we have come to realize that OT products kept in the patient's home are, in some instances, therapeutic because they provide emotional support by association. The following case history is an example:

> A 28-year-old housewife developed a postpartum psychosis, with suicidal and infanticidal impulses. She recovered after intensive treatment which included electroshock. During the week before her discharge, she completed a stuffed teddy bear which she took home with her. She treasured this stuffed animal for several years, slept with it, and during the daytime derived a sense of security from touching it.
>
> Four years later she delivered another baby, and a few months later became sick again, again displaying suicidal and infanticidal impulses. She told her husband that she had thrown away the teddy bear because it had been worn out with constant handling and had fallen apart. By this destruction of her love object she dramatized the fact that she could no longer function at home. She returned to the hospital voluntarily, and again received intensive treatment. In OT she again started to work on a teddy bear, but complained bitterly all the time. In spite of her best efforts, the stuffed animal kept coming apart at the seams. Her lack of progress with this work paralleled her failure to respond to treatment. After three months, she was transferred, unimproved, to a state hospital for further treatment.

*Formerly Chief Resident, Dept. of Psychiatry, Mt. Sinai Hospital.

THE WARD COMMUNITY:

A New Route Toward Long-Standing Goals

By CARL L. McGAHEE, M.D.
Senior Psychiatrist
Rockland State Hospital
Orangeburg, New York

THE TRANSITION of the state hospital from a custodial institution to an active rehabilitation agency has been far from smooth and is still incomplete. Traditional methods of caring for large patient-populations seldom lend themselves to active treatment programs. An example is the long-established practice of grouping patients on a hospital ward according to their condition. A disturbed patient is not helped by being with two dozen other disturbed patients; the self-perpetuation of a "disturbed ward" is a commonly observed phenomenon. Too much homogeneity will stultify progress.

Stable Community Never Develops

The female reception building of Rockland State Hospital, with which this study is concerned, is typical. It includes an admission ward, sick ward, disturbed ward, semi-disturbed ward, ambulatory senile ward, four closed wards, and three open wards. As a patient's condition changes, she is moved to the appropriate ward. Under this procedure the wards remain homogeneous and administration is simplified. But the development of a stable community group on a ward is impossible and patients are subjected to repeated stress of adapting to a new ward environment, new ward personnel, and a fluid, amorphous, ever-changing peer group.

In recent years, somatic therapies, especially chemotherapy, have raised hopes of having a limited number of personnel apply intensive treatment to a massive patient-population. But these therapies have no lasting effect without some form of psychotherapy to eliminate maladaptive and self-defeating behavior. This recognition has stimulated the application of psychotherapy and re-education by group methods. Maxwell Jones' concept of the "therapeutic community" is particularly germane to the mental hospital.

The so-called "team approach"—the more effective and integrated utilization of ancillary services—is also directed toward effective rehabilitation. Yet, too often there is a sad lack of communication and cooperation between the psychiatrist, ward charge-attendant, social worker, psychologist, occupational therapist, and others. As a result, each functions on the basis of his own incomplete impressions and toward his own particular goals, which can lead to wasteful duplication and unwitting mutual sabotage.

In June 1960 we began a project in our female reception service to determine to what extent a hospital ward could be developed into an effective therapeutic instrument, or "therapeutic community." The author was put in charge of a 32-bed ward to which all his patients in the various "category wards" were transferred. As before, new patients were assigned from the admission ward as soon as possible. One caseworker was assigned to the experimental ward, so that the original team consisted of the psychiatrist, the caseworker, the charge attendant, and her assistant.

There were no other definite policies except to avoid, when possible, the transfer of patients out of the experimental ward. We correctly anticipated that a stable and variegated ward population would gradually organize itself into a stable "community."

Evolution of the "Ward Community"

There were some immediate and noteworthy happenings on the experimental ward. Patients who came from the "disturbed ward" improved almost immediately in this more placid atmosphere. Those who came from the open wards were reluctant at first, but were reconciled when they learned that they would retain their grounds privileges.

Initially, ward routines were established arbitrarily by the psychiatrist and the charge-attendant. But we at once set up weekly meetings for all patients and the ward team. We encouraged free expression of opinions and

suggestions. Morale increased steadily as the patients became more familiar with each other and accustomed to our consistent attitudes toward them. By the third month, they elected officers for patient-government, and at the end of six months were functioning smoothly in their daily routine with the help of the staff and patient-

Ward meetings, presided over by the ward chairman, are held weekly. The meetings are conducted in an orderly fashion, with the customary reading of the minutes, reports of the committees, and discussion of any new business. When necessary, separate meetings are held with the patient-government officers to discuss special problems.

By the third month, our program was operating efficiently. When a new patient is transferred to the ward, an appointed committee of patients welcomes and orients her. As soon as her condition warrants it—usually within the first week—she is assigned to a half day of activity in the occupational shop, a class, or one of the industrial therapies. During the other half day she is free to participate in organized recreation, rest, socialize, take walks, go to the library, or engage in any other available activity she likes.

As soon as she is well enough, a patient may go for a walk with another patient who has an honor card. When she has improved further and has learned her way about the on-limits area of the grounds, she, too, receives an honor card which carries ground privileges. All those with grounds privileges monitor, on a rotating basis, the door leading to the outside. Here patients sign in and out and state their destination.

During the third month, we formed a psychotherapy group of the nine best-integrated patients. The interaction and mutual observation resulting from their residence on the same ward facilitated interaction in the therapy group and provided fruitful material for discussion. We formed a second group during the sixth month, and are planning to organize a third and fourth group during the next few months, so that every patient will be in group therapy.

We have not instituted any formalized individual therapy, but the psychiatrist holds numerous individual sessions with patients to discuss particular problems, over-all adjustment, or progress. When appropriate, he prescribes casework by the social worker and holds frequent conferences with her. The psychiatrist, unlike those in hospitals where patients are assigned to various wards, need not spend nearly half a day visiting the wards with only enough time to exchange brief remarks with the attendant; he has much more time for contact with the patients and conferences with the personnel.

Evolution of the Team

The original team consisted of the psychiatrist, caseworker, ward charge-attendant, and her assistant, but since almost all the patients are assigned to off-ward activities, the supervisors of occupational therapy and industrial therapy were soon added.

During the fourth month we instituted a mutually profitable collaboration with another project sponsored by the National Institute of Mental Health, which had been in progress for two and a half years. This project, staffed by a social caseworker and vocational counselors, was to demonstrate in a large public mental hospital the value of the services of a hospital-based rehabilitation team with community ties. A private agency, Altro Health and Rehabilitation Service, and two public agencies, New York State Division of Vocational Rehabilitation and Rockland State Hospital, were cooperating in this project. Our ward program, which was in effect a rehabilitation program begun within the hospital, lent itself readily to the purposes of the vocational rehabilitation project. We in turn welcomed the opportunity of following through the experimental ward program to its ultimate goal—the full re-integration of the patient into the community.

Two Projects in Collaboration

All members of the project staffs—the experimental ward psychiatrist, caseworkers, ward charge-attendant, occupational therapist, industrial therapist, the regular vocational counselor from the division of vocational rehabilitation, and two vocational rehabilitation researchers —attend a weekly meeting to coordinate functions and facilitate communication between the two projects. The psychiatrist eventually discusses the history, mental status, illness, and prognosis of each of his patients. The ward charge comments about the patient's adjustment on the ward, and the occupational therapist usually is ready to give a preliminary report of her functioning in shop. The psychiatrist outlines the tentative treatment program, and explains early and distant goals. Comments and discussion follow. At the end of the meeting each staff member is clear about his particular function in the rehabilitation program for the patients reviewed.

About two thirds of the meeting time is devoted to follow-up reports on cases previously presented. These shared observations further clarify and expand the mutual understanding of patients' potentialities. Appropriate modifications of the program or goals, in part or as a whole, are made as indicated. Frequent informal meetings among various team members serve to clarify anything relevant to their respective interests.

We make no effort to "prove" the results of this project by any sort of statistical data, such as increased discharge rate, or decreased relapse rate. Such "proofs" are often spurious, and at any rate are not justified after only six months. Moreover, we are not suggesting a new therapeutic modality, but merely a way to implement treatment methods already accepted as effective.

Our results suggest forcefully that the state-hospital ward can function as a community unit, which can serve as a therapeutic instrument. But this is not feasible if the patients assigned to each psychiatrist are spread over a dozen wards on the basis of their behavior and shuffled continually as their behavior changes.

To develop a community atmosphere on a ward, patients should be placed, preferably on admission, on the ward where they may reasonably expect to remain throughout their hospital stay. All ward personnel should establish consistent and stable relationships with the patients. This is much easier when all the patients are

under the care of the same psychiatrist and ancillary personnel.

The ward community lends itself easily to the combined efforts of a treatment team—headed by the psychiatrist and composed of the ward attendants, a social worker, occupational therapist, industrial therapists, and vocational counselors. Close collaboration and communication among the staff is far more effective in understanding and rehabilitating the patient than when each service operates in relative isolation.

The development of the ward community can be expedited by the organization and cooperation of a patient-government group. This improves morale, releases the attendants from unnecessary supervision of ward chores, serves as a test of the patient's functioning, and offers a representative social setting in which patients can test insights and new modes of interaction learned in psychotherapy.

Small psychoanalytically oriented therapy groups of eight or nine profit from their shared experiences on the ward, and "feed back" to stimulate healthier interaction and functioning.

Stability Good for Research

The advantages of a stable ward community as a basis for further research projects seem clear. The difficulties in evaluating a new therapeutic agent, such as an experimental drug, are enormous when numerous variables, other than the one being tested, are present. Some of these variables are eliminated on a single ward where a relatively stable and standardized program is well established.

Our experience suggests that only two types of patients are unsuitable. The first are those who are so deteriorated or debilitated that they must have almost total continual supervision. However, we found that senile patients with extreme organic impairment responded very favorably to the well-structured environment and were able to contribute surprisingly to the ward activities. The second type are the dangerously suicidal or homicidal, or grossly disturbed patients with unsatisfactory or delayed responses to chemotherapy. In practice, only two of our patients had to be transferred to a maximum security ward during the entire six-month period.

The allocation of an entire ward to dangerous and difficult management cases seems obsolete in view of the treatment methods now available, but some small segregated area for such patients still remains necessary.

Grateful acknowledgement is given to the members of the team whose enthusiasm and cooperation made the success of this project possible: Mrs. Loretta Lewis, charge-attendant; Mrs. Rosa Rodwell, attendant; Miss Sara Kossin, psychiatric social worker; Mrs. Marion Phillips, occupational therapist; Mrs. Ella Christianson, industrial therapist; Mrs. Catherine Milos, vocational counselor; Mr. Meye Siegel, vocational counselor; and Mr. Jack Consenstein, psychiatric social worker.

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1. Morrison, J. E.: Hospitals *33*:97 (July 16) 1959.
2. Laitner, W.: Psychiat. Quart. Suppl. II *29*:190, 1955.

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INSTITUTIONAL WAREHOUSING *ON THE MOVE*

By BRUCE L. ROBERTSON
Food Service Advisor
Department of Mental Hygiene
Albany, New York

MANAGEMENT PROCEDURES in mental hospitals often lag behind new methods developed in private industry, but eventually they catch up, especially when the advances become so obvious. For example, "materials handling" is a technical term which has been too long associated only with commercial manufacturing activities. Five years ago, however, the New York Department of Mental Hygiene fell in step toward this "new" horizon and made some giant strides in institutional warehousing.

Many a casual onlooker pictures materials handling as a fork-lift truck with rider, a giant steam shovel, or a gangling crane. It is much more than that. Skid jacks, pallets, "walkie stackers," or just plain boxes are merely tools. Materials handling is the coordination of standard unit-loads, pallet patterns, pallet sizes, transportation requirements, equipment specifications, etc., between processor, warehouseman, and user.

This new field, as defined by the Materials Handling Institute, Inc., of Pittsburgh, Pa., consists of four basic theoretical elements: motion, time, quantity, and space.

1. *MOTION*—Parts, food, and medical supplies, etc., must be moved from receiving points or storage to areas of consumption. Materials handling moves them in the most efficient manner.

2. *TIME*—Operating functions in any institution require that supplies be on hand the moment they are needed. Good hospital materials-handling practice requires that no phase of patient treatment or care be hampered by supplies arriving too late or too early.

3. *QUANTITY*—Each department area of receipt and consumption should receive continuously the right quantity of parts, gallons, or pounds.

4. *SPACE*—Whether space is active or dormant it costs money. Good materials-handling practices, including flow patterns, make effective use of cubic as well as square footage.

It was with these functions in mind that we turned to the practical application of materials handling in our New York institutions.

We began by investigating flow-process charting, and arrived at some rather obvious conclusions. We found frequently that a single case of canned goods was handled as many as 11 times from the time it left the warehouse until it was used in the kitchen. This involved receipt, checking in, storage, order picking, checking out, loading of delivery trucks, unloading at kitchen docks, and eventually transfer to the kitchen proper. The most apparent need was to apply the unit-load principle.

We made a simple comparison between two of our institutions, by requisitioning food supplies to be sent from the warehouse to kitchens, for approximately 1,000 patients for one week. Institution "A" did not have materials-handling equipment and Institution "B" used the most modern equipment and the unit-load principle.

ONE TRUCK can deliver groceries to all kitchens when modern equipment is used, and loading is done on the unit-load basis.

ELECTRIC and hydraulic pallet jacks and a hydraulic tailgate facilitate loading and unloading. Kitchen dock heights vary.

"HI, CHEF, here's your order." Materials-handling techniques effected delivery twenty times faster than could old methods.

Institution "A" took a total of 21 man-hours and the personnel involved walked a total of 3.9 miles. Institution "B" required a total of 1.05 man-hours with a travel total of .748 miles. In effect, Institution "A" took approximately 20 times as long to accomplish identical procedures.

These figures bore out our contention that we had to stop thinking of our warehouses as storehouses for goods, with square footage and manual labor. We had to think of them as distribution facilities with cubic footage and powered equipment.

Any institution warehouse should have seven basic functions: (1) Receiving; (2) Sorting and stacking; (3) Storing; (4) Order picking; (5) Order assembling and packing; (6) Shipping; (7) Inventory control.

With this outline in mind, we analyzed our general building requirements. We studied practices and building specifications of commercial warehouses, looking into *everything* they did and attempting to relate these activities and facilities to our own operations.

One-Story Building Best

We found that a one-story building, where possible, was the unit we needed. It costs far less than buildings requiring sufficient mechanical strength to support a second or third floor, and lends itself to newer types of roof construction with longer truss spans. It eliminates or reduces space needed for stairs, elevators, and columns One of the many studies available indicates that up to 19% of a warehouseman's time is lost in elevator operations.

However, all of these advantages cannot be realized fully unless powered materials-handling equipment is used. Thanks to the close cooperation of our fiscal officers, architects, and engineers, our final system included all the essentials.

Before this study, our warehouses contained various climatically controlled rooms to accommodate items bought under previous purchasing and delivery policies. We had thought it economical to purchase and deliver large quantities to our institutions for storage. However, often in evaluating such costs as a refrigerating room for three-months' storage of cereal products, or a zero-degree refrigerator for a 3- to 6-month storage of butter, we found it more economical to use normal storage for a one-month supply of cereal, or a 35° refrigerator for one-month's supply of butter. Canned goods, previously purchased and delivered for a 6- or 9-months period, are now procured for the same period *but* delivered every three-months, which reduces climatic requirements to a minimum and lowers the building and maintenance costs. Substantial economic gains indicate that this approach is correct.

In determining space layout for our warehouses we took into consideration: (a) climatic requirements of the materials to be stored; (b) variations in size, weight, shape, and crushability; (c) activity; (d) quantity; (e) items issued in off-size package units.

These factors also changed our thinking. Instead of the built-in, walk-in type refrigerator, we obviously needed a prefabricated type of walk-in with maximum flexibility in case of changes in population, food ration, or purchasing policies. We needed large unobstructed rooms for palletization, flexibility of storage areas, simple space layouts for storing uniform packaged goods, and

facilities where all items could be moved quickly and efficiently. We tried always to avoid constructing or purchasing "obsolescence."

We recently completed one of these new warehouses and are extremely pleased with the results. Although it contains production centers (butcher shop and centralized vegetable-preparation area) and storage areas, it costs less per square foot than our older buildings.

Our study also showed that materials-handling principles and equipment could be used in many of our existing warehouses. For instance, Institution "B" found that by planning its operation thoroughly the number of times each case, crate, or package is handled from delivery at the warehouse until used in the kitchen can be reduced to exactly one—order picking in the warehouse.

A well-coordinated materials-handling system throughout an institution offers advantages in many areas other than the warehouse. Before getting proper equipment and a suitable warehouse, Institution "B" required one and one-half trucks a day for delivering groceries to a number of kitchens within the institution. With the new equipment—electric and hydraulic pallet jacks for loading trucks with the unit-load principle—one truck services the kitchens and delivers goods from the bakery and processed vegetables from a central vegetable-preparation room. A hydraulic tailgate facilitates loading and unloading the delivery truck because dock heights vary.

Starlet Replaces Chorus Line

Movement of goods in the past always required large groups of employees and patients but practicing the age-old principle of "first in—first out" no longer resembles a crowd scene in a movie. We have demonstrated that even a lady operating good equipment can receive, sort, stack, and store 375 cases of canned goods in less than 20 minutes. Our efforts finally proved that the materials-handling process is the best method available for fast, efficient, and economical warehousing. •

". . . and in return for excellent salaries, fringe benefits, staff recreation programs and so forth, the hospital expects just one thing . . ."

Drying Up the Towel Problem

By FREDERICK HENKES
Stores Clerk III
Fergus Falls State Hospital
Fergus Falls, Minnesota

FOR YEARS we tried unsuccessfully to find a practical, economical way of furnishing towels for patients to use in the washrooms of our 2000-bed hospital. We issued towels from the nursing stations upon request, but the patients found this too inconvenient and ended up drying themselves on their clothing. We supplied towels in the washrooms but they were used as cleaning rags or disappeared down the toilets. We put grommets on towels and fastened them onto a chain, but then one patient would use all the clean towels available. Paper-towel holders proved unfeasible because a minority of the patients wasted towels.

Finally, we contracted for a trial installation of 74 roller-towel cabinets on our most troublesome wards. The cabinets have a time-release feature to prevent excessive use of toweling. After one year, the cost averaged only $40.35 per cabinet. In addition to being economical, the cabinets provided the following advantages: (1) since towels cannot be thrown into water closets, our problem of clogged sewers has been reduced; (2) towels cannot be used as cleaning rags and, therefore, are not excessively stained or soiled; (3) sewing room personnel save time and material in making towels; (4) there is no unreasonable use or destruction of cabinets or towels.

Results Are Convincing

We were convinced that the roller-towel system was the best solution to our problem and decided to expand it to all wards. We compared the cost of purchasing cabinets and towels outright as opposed to rental charges, and estimated that we could purchase all needed equipment and supplies for $8,361. We discovered that our laundry facilities could accommodate the additional cleaning load of the toweling if we obtained a soiled-towel unwinder and a dry-towel winder.

The cost of renting the same number of roller towels came to $7,665 a year. Therefore, considering the cost of laundering and replacing towels, we would save about $5,000 by buying the equipment. This includes amortization of cabinets on a nine-year basis because the cost of replacing them is very small.

The benefits of this system are not measured so much in dollars saved as in patients who can now dry their own hands and faces without unnecessary waste and without the problems incident to other methods. •

Patients Evaluate the Food Service

By RUTH VAN ANDEN
Supervising Dietitian
Hudson River State Hospital
Poughkeepsie, New York

THE FOOD-MANAGEMENT field has many erudite experts in the art of fine cooking and the science of nutrition, but cooking by the book doesn't always pass the test of the taste buds. For this reason, we measure our food service at Hudson River State Hospital by the patients' seal of palate approval.

The first Monday of each month, the supervising dietitian and the food manager conduct a patients' food-committee meeting which is attended by 12 to 14 men and women patients representing their particular wards. The group meets for about an hour in a small room in the administration building to discuss food preparation, food service, and food in general. Patients are encouraged to talk freely about anything pertaining to hospital food.

After a period of general comments, there is a round-table discussion in which each person is called upon for remarks. This prevents one or two people from monopolizing the meeting. When Mary complains that the Swiss steak was not tender or John says that the breakfast coffee was weak or Margaret prefers a new formula to an old one, we ask the others to give their opinions.

We Agree, but . . .

Occasionally, a patient will ask if milk and sugar can be served separately for cereals and beverages, and we may agree to try it in his particular dining room. However, if patients begin to add sugar to vegetables, soups, and desserts as well as to cereals and beverages, we must revert to our former method of service. Sometimes patients request salt and pepper shakers for tables in areas that do not have them. When we explain that shakers were provided but have disappeared, Tom or Bill may offer to be responsible for new ones if we will furnish them again.

Patients may want specific food items—usually an additional glass of milk or second cup of coffee. They are understandably amazed when we point out that if we provided another glass of milk to each person, in addition to the regular pint of milk a day, it would cost the hospital about $180 a day or approximately $65,000 a year. Moreover, we prefer to serve one good cup of coffee, rather than two cups that induce complaints, so we use two pounds of coffee to five gallons of water for 100 people. Patients agree that one good cup is better.

If a committee member expresses his dislike for certain food formulas and a plate-waste study reveals that the majority share his dissatisfaction, the offending foods are eliminated from the dietary. We responded to frequent comments about certain meat-extender dishes—macaroni, spaghetti, noodles and rice—served intermittently for supper, by serving meat sauce over the spaghetti, substituting grilled-cheese sandwiches for macaroni and cheese, and using a bread dressing with turkey instead of noodles. Our patients welcomed the changes.

Women complain particularly about gaining weight and think the menus are too starchy. When this happens, we analyze the menu's nutritional value and compare it to standards recommended by the Food and Nutrition Board of the National Research Council. Since menus do exceed the recommended daily dietary allowances for specific nutrients, we suggest that those who are gaining weight should take one slice of bread instead of two, eat sparingly of puddings and cakes, and purchase fruit or "No-Cal" soda at the community store instead of candy and sundaes.

Some patients bring lists of comments from the people in their buildings; others have records of actual menus served since the last meeting. Comments are not always critical; some are complimentary, and it is gratifying to know how much the patients appreciate our efforts.

Patients stop us often when we are making rounds to ask, "When is the next food meeting?" Their interest in food encourages us and we have found that the meetings are helpful in planning future food requirements. We have eliminated unpopular foods and added others that have been requested. We have become aware of weak points in the kitchens and dining rooms. Most important, we in the food service department have formed closer and friendlier relationships with the patients. •

"Davis, you've been nibbling at the High Energy diet again . . ."

REVIEWS & COMMENTARY

FILM REVIEW

HELP WANTED (color, 28 minutes) Produced by Nebraska Psychiatric Institute. For information about availability, write to NPI, 602 South 44th Avenue, Omaha, Nebraska.

ALTHOUGH THERE HAVE BEEN a number of recent mental health films about the job-seeking problems of the discharged mental patient, none have shown the part played by the vocational rehabilitation counselor. Readers who are familiar with such excellent films as "Bitter Welcome" and "A New Chapter" will recall that, in both films, the ex-patient tackles the problem more or less on his own, although with supportive counseling from a physician. An older film, "Back to Life," showed something of the rehabilitation counselor's work, but there always seems to be room for one more in this field, and film users in hospitals will welcome NPI's new "Help Wanted."

This film is *all* about the VR counselor, showing him as part of the hospital's therapeutic team. It makes clear that, to do a really effective job, the counselor must work with the patient *before* separation from the hospital. He interviews the patient first, followed by the occupational therapist, the social service department, and the psychologist—all of whom size up the patient's potential for employment. Another important aspect of the VR counselor is also clearly delineated; he is a vital link to the community, working with the state employment agency and sheltered workshops.

To tell this story, the NPI film makers give us two case histories. The first is that of an attractive young girl with a favorable prognosis. A secretary before hospitalization, she wants to return to this kind of work and is encouraged to enroll in a local business school to refresh her typing skills, although she returns to the hospital every night. Role-playing sessions with the counselor help her to handle her fear that she might be stigmatized by her mental illness, and discourage her dependency on the counselor. The second case is less hopeful since it is that of an older man with some deterioration. Although he seems difficult to place at first, he goes through a series of evaluations in a sheltered workshop setting. Progressing through a number of useful jobs (for which he is paid), he eventually acquires new skills and self-confidence and leaves the workshop for a satisfying job. This case history shows the importance of such community resources as Goodwill Industries and the state office of vocational rehabilitation.

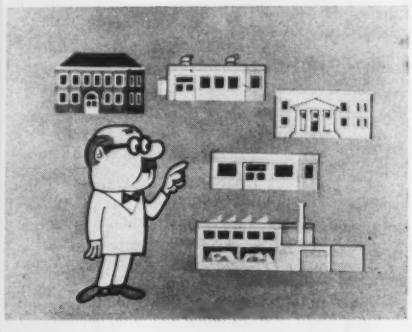
The production has thoroughly professional quality. Although the acting is somewhat low-key, it is always convincing—doubtless because the persons playing hospital staff members were enacting their real-life roles. A well-written script and skillful direction and editing help to sustain interest in the story.

"Help Wanted" will have many uses. With hospital staff, it could be used for orientation purposes. Some hospitals may even want to consider using it with patients to spark their interest in the vocational rehabilitation program. Possibly its best use would be with the outside community—with prospective employers, for example. It might also be shown to high school and college students to stimulate their thinking about a career in vocational rehabilitation counseling. Nebraska Psychiatric Institute is to be congratulated for this fine addition to their film series examining the numerous disciplines and the many kinds of people who help the mentally ill.

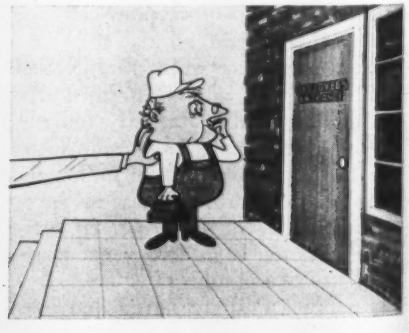
JACK NEHER
Mental Health Materials Center

VR counselor as he appears in opening, closing animated sequences of HELP WANTED.

He knows uses of all community facilities—schools, employment agencies, other resources.



Some ex-patients need support and guidance in their search for employment, acceptance.



READERS' FORUM

Sheltered Workshop

WE READ WITH INTEREST Dr. Baur's letter in the April issue of Mental Hospitals. In it, he asked for comment from others who have started a sheltered workshop, so we will pass along what information we have.

Two months ago we contracted with the Coca-Cola Bottling Company of Great Bend, Kansas—about 20 miles from the hospital—to repair cartons. The company pays us at the rate of 20¢ per carton for repair, 5¢ for painting, and 1¢ for stenciling the trademark on each side of the carton. Six patients do this work from 8 a.m. until 10 a.m. Another group of six works from 10 a.m. until noon. As more space becomes available to us, we intend to add more patients and have them work half days.

We are trying to place patients in an actual work situation. Both male and female patients participate under the supervision of a work therapist. They check in and out at stated times and are paid according to the amount of work they do. Hopefully, one day we will be able to share the money equally among the patients. Payday is every other Wednesday; the company deposits the money in the hospital funds, and the hospital issues checks directly to each patient to save or spend as he pleases. The way in which patients handle their checks is significant to us when we consider their dismissal from the hospital.

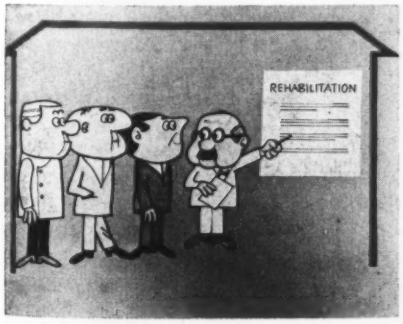
As soon as the project is definitely on its feet, our psychology department will use it as a test situation for eventual job placements. We recommend workshop activities for patients who have been in the hospital for some time, possibly could work on the outside if they first gain experience, and can make enough money to tide them over for a time after they leave the hospital. If patients are able to cope with the work situation, we begin planning their discharge.

The company furnishes parts, nails, paint, stenciling machine, and other necessary equipment. The hospital furnishes hammers and screwdrivers. The company also stocks the cases on the hospital grounds and takes the finished cartons back to its plant. Once a week it delivers wooden partitions and ends for the cases.

This experiment is so new that we cannot make definite decisions about it yet, but we believe that it will be one of the very fine activities in the hospital. Patients who formerly displayed little inclination to work now wait outside for the workshop to open, and many would like to continue past the closing time. On payday they are like any similar group of workers on the outside, assembling a little ahead of time to be sure they will be among the first to get their checks.

Ted O. Irwin *Coordinator, Adjunctive Therapies*
Frank V. Smith, M.D. *Superintendent*
Larned State Hospital
Larned, Kansas

Vocational counselor always works closely with the treatment team in the mental hospital.



BOOK REVIEW

THE CRISIS IN PSYCHIATRY AND RELIGION—by O. Hobart Mowrer, Ph.D. Princeton, N. J., D. Van Nostrand Company, Inc., 1961, 264 pages, $1.95.

This is a paperback collection of papers Mowrer presented to a variety of professional groups representing, in the main, theology, psychology, and psychiatry. As the author himself states, his material is global in scope and controversial in nature. His central theme is this:

"We have tried to believe that personality disorder is basically an illness—mental illness; but we are now

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increasingly persuaded that the problem is fundamentally moral, that the guilt which is so obviously central in psychopathology is real rather than false, and that only a moral attack upon the problem can be successful. We had hoped that an easy solution might be found for personal evil; and we have tried both the doctrine of 'cheap grace' (in religion) and the strategy of denying the reality of sin and guilt altogether (in psychoanalysis), but neither has worked. And so today there is a growing readiness to accept the verdict that 'therapy' or 'salvation' is possible only at a great cost; the cost of self-revelation, deep contrition, and a radically changed way of life."

In the last three chapters—"Protestant Christianity: I. Ambiguity and Disaster," "Protestant Christianity: II. Challenge and Change," and "Footnotes to a Theory of Psychopathology"—Mowrer indicates generally what is involved in "self-revelation, deep contrition, and a radically changed way of life" from both a theoretical and a therapeutic point of view. He supports his position with case material.

This reviewer does not think that the psychoanalyst (classicist or aberrationist) who works out of a Protestant (Calvin-Luther-Zwingli) tradition will necessarily agree with Mowrer's interpretation that such tradition, theoretically, and when applied to the human situation, is "cheap grace." The Reverend Dr. Oskar Pfister, life-long friend of Freud, surely would not have accepted Mowrer's deprecation of psychoanalysis. Pfister did not always agree with Freud, particularly with some of his religious notions. However, he did continue to employ the psychoanalytic method in his tough pastoral cases. Mowrer, undoubtedly, is rather unrealistic in his approach to the "crisis" in psychiatry and religion when speaking in terms of "Freud is dead" or that psychoanalysis—as a body of knowledge, a research device, and a treatment method—is obsolete.

One psychoanalytic concept that Mowrer would like to see subsumed under the theological concept of "real" guilt is that of "neurotic" guilt; hence, "moral" illness in place of "mental" illness. Protestant theology postulates two kinds of guilt related to the idea of sin: (a) guilt (and the feelings) due to man's basic condition—estrangement from God, and (b) guilt (and the feelings) due to *acts* of sin. Interestingly, in this connection, justified feelings of guilt are often not "guilty" in tenor at all but manifest themselves in other kinds of feeling. The phenomenon of neurotic guilt (and the feelings) sometimes may be related in one way or another to guilt (and the feelings) due to man's estrangement from God; in specific circumstances it may be related to *acts* of sin. However—and this reviewer believes this to be the crucial issue—there are occasions when a person's expression of guilt (and the feelings) manifests itself in a variety of unique, complicated, symptomatic structures requiring some form of psychoanalytic procedure to penetrate, undo, and repair. Of course, there are therapeutic failures, but there are some successes too. A

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person's guilt (and the feelings) is a multi-variate phenomenon. Mowrer's wish to subsume "neurotic" guilt under "real" guilt represents to this reviewer a shuffling of the nomenclature to fit a multi-variate phenomenon into a single mold. Clinical observation and experience do not seem to warrant this position.

Mowrer has presented his view of the crisis in psychiatry and religion in an articulate and readable form. The "global" and "controversial" materials may serve as a guide to a program of discussions between the varied professions within the modern psychiatric hospital.

HERBERT P. FRITZE, B.D., M.A.

CURRENT STUDIES

This column lists investigations of interest to mental hospital personnel. Authors have agreed to make copies of their papers available. Requests should be sent to them directly, with 25¢ for postage and handling.

RECOGNITION AND REFERRAL OF PSYCHIATRIC ILLNESS ON A UNIVERSITY MEDICAL INPATIENT SERVICE

A representative sample of patients admitted to a university inpatient service over a three-month period was interviewed by psychiatrists within 24 hours of admission, and their diagnoses of mental illness were compared with those of the medical staff. An analysis of the medical service and staff was made to determine factors which affected referral rates. Copies of this study are available from: Henry E. Payson, M.D., Dept. of Psychiatry, Yale University School of Medicine, 333 Cedar Street, New Haven 11, Conn. (*This paper was presented at the 117th Annual Meeting of the A.P.A. in May 1961.*)

NOTES ON A PRIVATE PSYCHIATRIC HOSPITAL.

In this study, the author has attempted to formulate in summary fashion the basic thoretical and practical principles involved in a psychoanalytically oriented private hospital. These ideas are a combination of personal professional opinions and recommendations based on actual experience of private and hospital practice. Available from: Mehl McDowell, M.D., 1019 Gayley Avenue, Westwood Village, Los Angeles 24, Cal.

INTER-GOVERNMENTAL RELATIONS AFFECTED BY A RE-ORGANIZATION OF THE MICHIGAN MENTAL HEALTH PROGRAM

A committee appointed by the Lieutenant Governor of the State of Michigan made recommendations for changes in the organization of mental health facilities within the state. The present organization of these facilities and the effect the committee's recommendations would have on them are discussed in this paper. Copies are available from: George B. Schieve, Business Executive, Ypsilanti State Hospital, Ypsilanti, Michigan.

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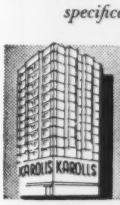

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NEWS & NOTES

New Mental Health Traineeship for Graduate Nurses

THE MENTAL HEALTH TRAINEESHIP PROGRAM established under the National Mental Health Act of 1946 has been extended to include a limited number of undergraduate traineeships in schools participating in the National Mental Health Training Program. Stipends of $1,800 annually plus tuition and registration fees are available to graduate nurses for full-time study to complete the senior year of a baccalaureate nursing program which provides undergraduate training in all clinical areas. Applicants *must* be interested in continuing study in a graduate psychiatric-mental health nursing program upon completion of the baccalaureate program. Trainees are selected by the educational institution awarding the traineeship.

The Mental Health Traineeship Program continues to provide support for nurses seeking specialized graduate study in the field of psychiatric-mental health nursing and related areas.

For further information about traineeships, write to the Training Specialist in Psychiatric Nursing, Training Branch, National Institute of Mental Health, National Institutes of Health, Bethesda 14, Md.

QUARTERLY CALENDAR

A.P.A. ANNUAL MEETINGS

1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Sheraton-Fontenelle Hotel, Omaha, Neb. (13th)
1962 Sept. 24-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Sheraton-Gibson Hotel, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel America, Boston, Mass. (16th)

OTHER A.P.A. MEETING

Divisional Meeting, September 21-23, Hotel Utah, Salt Lake City
Chairman: Dr. Myrick Pullen, Orofino, Idaho

CANADIAN MENTAL HEALTH SERVICES INSTITUTE

1962 January 15-18, Chateau Laurier Hotel, Ottawa, Ontario (2nd) (Inq. Dr. V. E. Chase, Canadian Psychiatric Assn., Suite 103, 225 Lisgar St., Ottawa 4, Ontario)

OTHER PROFESSIONAL MEETINGS

AMERICAN ASSOCIATION FOR REHABILITATION THERAPY, Annual Meeting, Scientific and Clinical Conference, *July 10-14,* Indiana Univ. Medical Center and Sheraton Lincoln Hotel, Indianapolis, Ind.

INTERNATONAL PSYCHO-ANALYTICAL ASSOCIATION, Congress, *July 30-August 3,* Edinburgh, Scotland. (Inq. Hon. Sec., 37 Albion St., Hyde Park, London, England.)

INTERNATIONAL CONGRESS OF PSYCHOTHERAPY, *August 21-26,* Vienna, Austria. (Inq. Dr. W. Speil, Lazarettgasse 14, Vienna 9, Austria.)

INTERNATIONAL CONGRESS OF GROUP PSYCHOTHERAPY, *August 24-27,* Paris, France. (Inq. Dr. W. J. Warner, P.O. Box 819, Grand Central Sta., New York 17, N. Y.)

WORLD FEDERATION FOR MENTAL HEALTH, International Congress on Mental Health, *August 30-September 5,* Paris, France. (Inq. Secretary General, WFMH, 19 Manchester Street, London W.1, England.)

AMERICAN PSYCHOLOGICAL ASSOCIATION, Annual Convention, *August 30- September 6,* New York, N. Y.

AMERICAN HOSPITAL ASSOCIATION, Annual Meeting, *September 25-28,* Atlantic City, N. J.

CANADIAN ASSOCIATION FOR RETARDED CHILDREN, Annual Meeting, *September 26-28,* Hotel Vancouver, Vancouver, B.C.

Remotivation Highlights

"THERE ARE MANY KINDS of group activities which have been developed within the hospital treatment program; the Remotivation technique is specifically used by the psychiatric aide supervised by the professional nurse, and is an integral part of total nursing care," declared the advisory committee of the APA-Smith Kline & French Remotivation Project during its May meeting.

The Committee recommended that remotivation be taught to and used by psychiatric aides, but that other groups can profitably participate in activities designed to assist the aides. Volunteer workers, for instance, are invaluable in collecting materials, poems, visual aids, and so on for the use of the aide-group leaders. Hospitals with a remotivation program should encourage such volunteer support.

The Committee, after noting that Western State Hospital in Kentucky has been named as a regional training cen-

ter, gave its approval to establishing similar training centers in Indiana, Kansas, Massachusetts, and Minnesota. It likewise approved a training proposal for the Western provinces of Canada. The establishment of similar centers in Colorado, Arizona, Louisiana, Iowa, Nebraska, Rhode Island, and Wisconsin will be explored. Emphasis will be placed on extending the technique in hospitals for the mentally deficient.

Albert Deutsch Dies

HIS MANY FRIENDS will be distressed to learn of the unexpected death of Albert Deutsch, 55, in England, where he was attending a meeting of the World Federation for Mental Health.

Mr. Deutsch was an Honorary Fellow of the APA, and was active in the National Association for Mental Health. In 1949 he received the Lasker Award for Mental Health, and in 1953 the Adolf Meyer Memorial Award in Mental Hygiene.

At the time of his death, Mr. Deutsch was engaged in a comprehensive survey of the status of psychiatric research in the U. S. and had planned to publish his findings in book form.

Few free-lance writers have made such a contribution as Mr. Deutsch in furthering the cause of humane and scientific treatment of mental illness. His two books, *The Mentally Ill in America: A History of Their Care and Treatment Since Colonial Times* and *The Shame of the States*, are classics in the history of mental illness in the United States.

APA Library Acquires Adolf Meyer's Collection

MRS. ADOLF MEYER, widow of the late Dr. Meyer, has presented the APA library with 3,000 volumes from her late husband's collection. The volumes include first editions of works by Isaac Ray, Heinroth, Andre Marie, Janet, Bleuler, Freud, Southard, W. A. White, Hake Tuke, and Morton Prince. Many of these are autographed copies presented by the authors to Dr. Meyer.

Miss Eunice Winters, Dr. Meyer's biographer and former assistant, did much to assist Mr. O'Mara, the APA librarian, in the transfer of this collection, as did Dr. George Mora, of the APA Committee on the History of Psychiatry.

The Meyer collection will form the nucleus of a national historical library of American psychiatry, which is to be housed in the Modern Founders' Room of the APA Central Office. Those interested in contributing classic works for the library may obtain a preliminary list of books and documents especially desired.

Another notable gift was a first edition (1895) of Breuer and Freud's *Studien Uber Hysterie*, donated by Dr. Joost A. M. Meerloo, who visited the Central Office with his wife early in May.

PEOPLE & PLACES

NEW OFFICERS: **Earl K. Holt, M.D.,** a Concord, N.H., psychiatrist and former superintendent of the State Hospital in Concord, has been elected president

Mental Hospitals Reprint Service

Readers frequently request reprints of articles in *Mental Hospitals* for distribution to others for various educational and informational purposes. The price list and order form below have been devised to simplify the procedure for obtaining reprints. Since it is not economical to reprint less than 100 copies, the minimum price is based on that number. Reprints are exactly the same size as the originals in the magazine and take the same number of pages. Prices quoted include handling and shipping costs. *Please enclose a check or money order for the exact amount with your order.* Delivery will take approximately three weeks.

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